Fax Completed form to:
1-888-261-7116

Referral for Medical Cannabis Assessment

1. Patient Information

First and Last Name	**Veteran ID #** *(K#)*	
Health Card # *(Include version code and expiry)* **or M/R/UCI#**	**Date of Birth** *(MM/DD/YYYY)*	**Gender** ☐ Male ☐ Female ☐ Other Pronouns:
Address: *(Include appt#, City, Province, Postal Code)*	**Home:** **Cell:** Can a voicemail be left? ☐ Yes ☐ No ☐ Text message may be sent	
Email:	**Patient Caretaker / Authorized persons** *(ie: family members)*	

2. Health Information

Presenting Symptoms *(eg. Pain/Sleep Issues/ Spasms)*

Treatments/Medications Used

Stated Conditions/Diagnosis *(eg. Arthritis/Insomnia/MS)*

3. Referring Healthcare Provider Information

Full Name _____

Office Address _____

_____ _____ _____

Billing # **Telephone** **Fax**

_____

Referring Healthcare Provider Signature

Services Available Nationwide
Canadian Cannabis Clinics offers virtual (Telephone/Video) appointments to patients across Canada

canadian cannabis clinics

P: 1-888-256-7043 F: 1-888-261-7116
E: hello@cannabisclinics.ca