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REFERRAL FOR MEDICAL CANNABIS ASSESSMENT

NOTE: Out-of-basket billing codes are used exclusively to ensure no penalty to referring physician.

PATIENT INFORMATION

Patient Full Name: _____
DOB (MM/DD/YYYY): _____ / _____ / _____ OHIP Number: _____
Phone Number: _____ (Daytime) _____ (Evening)
Address: _____
Email Address: _____ **Check if Rostered Patient:**

MEDICAL INFORMATION

Diagnosis and Symptoms: _____

Current Treatments and Medications: _____

Previous Treatments and Medications: _____

Additional Information: _____

REFERRING PHYSICIAN

Name: _____
OHIP Billing Number: _____
Phone: _____
Fax: _____
Email: _____
Address: _____
Signature: _____

