NATIONAL ACCESS CANNABIS

Referral Form

Fax to 613 729-9065
OR
Drop off at 1111 Wellington St. West

Patient Information

Name: _____

Health Card #: _____

Street Address: _____

Telephone # _____

City/Province/Postal Code: _____

Date of Birth (MM/DD/YYYY) _____

Can a voice message be left at this number to schedule an appointment? Yes ◯ No ◯

Patient Diagnosis and Symptoms:

_____

_____

Current Treatment/Medications:

_____

_____

Other Relevant History

_____

_____

Reminder Checklist

◯ (Required) Referral form completed

◯ (Supplementary) Additional Medical Documents supporting client diagnosis

◯ (Supplementary) Prescription and treatment history for anything not described on the Referral Form

A consultation appointment will be scheduled once ALL the requested information has been received and reviewed.

Referring Physician: _____ OHIP Billing #: _____

Address: _____

Telephone: (_____) _____ - _____ Fax: (_____) _____ - _____

Signature: _____ Date (MM/DD/YYYY): _____ / _____ / _____

let's talk answers