NATIONAL ACCESS CANNABIS

Referral Form

DR. Gilda Bowdridge
5990 Spring Garden Rd.
Halifax, NS B3H 1Y6

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 Treatments/Medications:

_____

_____

Previously Used Treatments/Medications:

_____

_____

Other Relevant Medical Information:

_____

_____

◯ (Required) Referral form completed by Licensed Physician

◯ (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: _____ Provincial Billing #: _____

Address: _____

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

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

let's talk **answers**