



# Referral Form

Please Fax to (613) 729-9065

OR

Email to: [Ottawa@NationalAccessCannabis.com](mailto:Ottawa@NationalAccessCannabis.com)

## 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:

\_\_\_\_\_  
\_\_\_\_\_

### Reminder Checklist

(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**