

1. Patient Information

First and Last Name	Veteran ID # (if applicable) K	
Health Card # (include version code) or M/R/UCI #	Date of Birth (YYYY/MM/DD)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Address	Telephone (Home) (Mobile)	
City / Province / Postal Code	Can a voicemail be left at this number for an appointment? Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="checkbox"/> Send my appointment details by text message	
Email <input type="checkbox"/> Send my appointment details by email	Patient Caretaker (to contact, if applicable)	

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2. Health Information

Presenting Symptoms (e.g. Pain/Sleep Issues/Spams)

Treatments/Medications Used

Stated Conditions/Diagnoses (e.g. Arthritis/Insomnia/MS)

IMPORTANT: Include recent investigation and consultation reports.

Please fax all supporting documents to **1-888-261-7116** or **1-905-688-2882**.

A consultation appointment will be scheduled and communicated once ALL the requested information has been received and reviewed. The referring provider will receive an acknowledgement of referral and information on the scheduled appointment date.

3. Referring Physician Information

Full Name

Office Address

Billing # Telephone Fax

Physician Signature

4. Select a Clinic

Alberta

☐ Calgary* ☐ Medicine Hat

☐ Edmonton

Ontario

☐ Burlington ☐ Ottawa (Nepean)

☐ Guelph ☐ Peterborough

☐ Hamilton* ☐ St. Catharines

☐ Kingston ☐ Whitby

☐ Kitchener ☐ Windsor

☐ London

☐ Mississauga

☐ Ottawa

*Affiliated clinics

5. Fax Completed Form

Fax to **1-888-261-7116** or **1-905-688-2882**.

Your patient will be contacted directly to schedule an appointment. A consultation report will be provided after the appointment.