Referral Form

hello cannabis

Patient Information

First Name _____ Last Name _____

Date of Birth (MM/DD/YYYY) _____ Health Card No. _____

Address _____

City _____ Province _____ Postal Code _____

Phone _____ Fax (optional) _____

Past/Present Prescription History _____

_____

Patient Medical History (Please attach relevant medical records)

AD/ADHD	Chrohn's Disease	Migraines
Alzheimer's Disease	Eating Disorder	Multiple Sclerosis
Anxiety	Epilepsy	Muscle Spasms
Arthritis (Severe)	Fibromyalgia	Muscular Dystrophy
Arthritis	Gastrointestinal Disorders	Nausea
Auto Accident(s)	Head Injury	Parkinsons Disease
Back &/or Neck Problems	Hepatitis	PTSD
Brain Injury	HIV/AIDS	Seizures
Cancer	Hypertension	Sleep Disorders
Chronic Pain	Irritable Bowel Syndrome	Spinal Cord Injury/Disease
Colitis	Kidney Dialysis/Failure	Other

Referring Physician

Referring Physician _____ Medical License No. _____.

Address _____

City _____ Province _____ Postal Code _____

Phone Number _____ Fax Number _____

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

contact us

Hello Cannabis
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A: 51 Cootes Drive, Dundas, ON, L9H 3B5

Please Fax Form to 1-855-808-3853