Referral Form

hello cannabis

Patient Information

First Name: _____ Last Name: _____

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

Address: _____ Gender: ☐ Male ☐ Female ☐ Other

City: _____ Province: _____ Postal Code: _____

Phone: _____ Fax (optional): _____

Email: _____

Past/Present Prescription History: _____

Patient Medical History (Please attach relevant medical records)

☐ Asthma	☐ Diabetes	☐ Irritable Bowel Syndrome	☐ Substance Abuse
☐ Cancer	☐ Epilepsy/Seizures	☐ Kidney Disease	☐ Stroke
☐ Chronic Pain	☐ Fibromyalgia	☐ Lung Disease	☐ None
☐ Colitis	☐ Heart Disease	☐ Multiple Sclerosis	☐ Other _____
☐ Crohn's Disease	☐ HIV/AIDS	☐ Migraines	_____

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
T: 1-877-281-1223
F: 1-855-808-3853
E: info@hellocannabismedical.com
A: 51 Cootes Drive, Dundas, ON, L9H 3B5

Please Fax Form to 1-855-808-3853