REFERRAL FORM
FOR PATIENTS SEEKING MEDICAL CANNABIS

PHONE: 1 800 730 8210 FAX: 1 855 597 8500

Patient Name: Telephone: _____

City, Province, Postal Code: Date of Birth: _____

Address: Health Card #: _____

Referring Doctor: Date:

Address:

Phone No: Fax No:

Billing No: Signature:

Are you a member of a FHO/FHT/FHN? Yes ☐ No ☐

PATIENT MEDICAL HISTORY

- ☐ ADD/ADHD
- ☐ Alzheimer's Disease
- ☐ Anxiety
- ☐ Arthritis
- ☐ Back &/or Neck Problem
- ☐ Cancer
- ☐ Other:
- ☐ Chronic Pain
- ☐ Colitis
- ☐ Crohn's Disease
- ☐ Eating Disorders
- ☐ Epilepsy/Seizures
- ☐ G.I. Disorders
- ☐ Head &/or Brain Injury
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ IBS
- ☐ Migraines
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Nausea
- ☐ Parkinson's Disease
- ☐ PTSD
- ☐ Sleep Disorders
- ☐ Spinal Injury/Disease

Current Medications/Treatments:

_____

_____

_____

_____

_____

Please send all relevant Medical records including specialist and diagnostic imaging reports. Patients will NOT be seen until all information has been received.

Select a Clinic

- ☐ Barrie
- ☐ Belleville
- ☐ Bracebridge
- ☐ Cambridge
- ☐ Cornwall
- ☐ Hamilton
- ☐ Lakeshore
- ☐ London
- ☐ Markham
- ☐ Newmarket
- ☐ North Bay
- ☐ Ottawa
- ☐ Peterborough
- ☐ Sarnia
- ☐ Sault Ste. Marie
- ☐ St. Catharines
- ☐ Sudbury
- ☐ Thunder Bay
- ☐ Timmins
- ☐ Toronto
- ☐ Windsor

FAX TO: 1 855 597 8500

YOUR PATIENT WILL BE CONTACTED DIRECTLY

Bodystream™ Medical Marijuana Services

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