Doctor Referral for Medical Cannabis Assessment

1. Patient Information

FIRST NAME	HEALTH CARD # (include version code)	
LAST NAME	DATE OF BIRTH (YYYY/MM/DD)	GENDER ☐ MALE ☐ FEMALE ☐ _____
ADDRESS	TELEPHONE (home)	(mobile)
CITY / PROVINCE / POSTAL CODE	Can a voicemail be left at this number for an appointment? Yes☐ No☐	☐ Text me with my appointment details
EMAIL		

☐ **Please check the box if you would like to be included in future communication and/or promotions from Emerald Leaf Cannabis Clinic. You may unsubscribe at any time by clicking the unsubscribe link at the bottom of our emails.**

2. Health Information

Primary Complaint:

Treatments/Medications Used:

Patient Diagnosis and Symptoms:

IMPORTANT: Include recent investigation and consultation reports.
PLEASE FAX ALL SUPPORTING DOCUMENTS TO (587) 469-3317
A consultation appointment will be scheduled once ALL the requested information has been received and reviewed.

3. Referring Physician Information

FULL NAME _____

ADDRESS _____

BILLING # TELEPHONE FAX

PHYSICIAN SIGNATURE

4. FAX to (587) 469-3317

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

Complimentary Comprehensive Cannabis Counselling

Guidance on a range of topics such as intake methods, dosage, and product selection. We assist patients with their licensed producer registration documentation and provide on-going care.

EMERALD LEAF
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Additional Forms at: www.emeraldleafmd.com/referral