Physician Referral Form

tcn The Clinic Network

www.theclinicnetwork.ca

Fax: 1-877-891-8371

Patient Name: _____

Date of Birth: _____

Address: _____

Email Address: _____

Contact Telephone: _____

☐ **Medical Cannabis Assessment**

Please fax/provide the following additional clinical information

1. Diagnosis/Reason for Referral:

_____

_____

2. Past Medical History/Current Medications:

_____

_____

Physician Signature: _____ Physician Name: _____

License Number: _____

Date: dd/mm/yyyy _____

Practitioner address: _____

_____

Tel: _____

Fax: _____

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