Physician Referral Form

tcn The Clinic Network

www.theclinicnetwork.ca

Fax: 1-877-891-8371

Patient Name: _____

Date of Birth: _____

Address: _____

_____

Contact Tel: _____

❑ **Medicinal Cannabis Education Only** ❑ **Medicinal Cannabis Authorization**

❑ **Medicinal Cannabis Assessment**

Please fax/provide the following additional clinical information:

1. Copy of any relevant reports / Letter from consulting specialist

2. Diagnosis/Reason for Referral:

_____

_____

3. Treatments tried to date:

_____

_____

4. Current medications:

_____

_____

5. Past Medical History

_____

_____

Physician Signature: _____ *Physician Name:* _____

License Number: _____

Date: dd/mm/yyyy _____

Practitioner address: _____

_____

Tel: _____

Fax: _____

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