



Medical Cannabis Referral

Patient Information

First name _____ Last name _____ Date of birth _____
Address _____
City _____ Province _____ Postal code _____
Email _____ Telephone _____

Referring Provider Information

First name _____ Last name _____
Profession _____ OHIP Billing Number _____
Office Address _____ City _____
Province _____ Postal code _____ Fax _____
Email _____ Telephone _____

Reason for Referral

Please attach any relevant diagnostic imaging with completed form.

Diagnosis:

Medications Exhausted:

Treatments Exhausted:

Referring Provider Signature

Name Signature Date