



# Physician Referral Form

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 Assessment

Please fax/provide the following additional clinical information:

1. Diagnosis/Reason for Referral:

2. Treatments tried to date:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3. Current medications:

4. Past Medical History

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Physician Signature: \_\_\_\_\_ Physician Name: \_\_\_\_\_

License Number: \_\_\_\_\_

Date: dd/mm/yyyy \_\_\_\_\_

Practitioner address: \_\_\_\_\_

\_\_\_\_\_

Tel: \_\_\_\_\_

Fax: \_\_\_\_\_

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