NATIONAL CANNABINOID CLINICS

Physician Referral Form

Tel: (416) 751-0990 / **Fax: (416) 751-0995**
info@ncclinics.ca / www.ncclinics.ca

Scarborough
208-4125 Lawrence Ave East
Scarborough, ON M1E 2S2

Richmond Hill
9212 Yonge street
Richmond hill, ON L4C 7A2

Keswick
716 The Queensway South
Keswick, ON L4P 4C9

Patient Name: _____ **DOB:** _____

Health Card No: _____ **Ver:** _____ **Tel:** _____

Address: _____

☐ **TELEMEDICINE** **Email:** _____

Reason for Referral:

☐ Arthritis ☐ Chronic Pain ☐ Fibromyalgia
☐ Cancer ☐ Multiple Sclerosis ☐ Sleep Disorder
☐ Gastrointestinal ☐ Seizure Disorder ☐ HIV/AIDS
☐ PTSD ☐ Mental Health: _____
☐ Other: _____

Medication for Condition:

_____
_____
_____
_____
_____

PMH: _____

_____

Referring Physician: PLEASE SEND SUPPORTING DOCUMENTS (imaging/bloodwork/consult notes)

Referring MD: _____ **Billing No.:** _____

Address: _____

Tel: _____ **Fax:** _____

Signature: _____ **Date**: _____
Are you a member of FHT/FHN/FHO? Yes__ NO__

(physician stamp)