STEPHANIE MASSEY
MEDICAL CANNABIS EDUCATOR

Referral Form

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PATIENT INFORMATION

First Name (s): _____ Last Name: _____

Birth Date: [M]_____ [D]_____[Y]_____ Gender: ☐ Male ☐ Female ☐ N/A

Phone #: _____ Email: _____

Patient Diagnosis and Symptoms:

_____

_____

_____

Current Treatment / Medications:

_____

_____

_____

Other Relevant History / Information:

_____

_____

Past Medical Treatments:

_____

_____

HEALTH CARE PRACTITIONER INFORMATION

First Name (s): _____ Last Name: _____

Profession: _____ License #: _____ Province Authorized to Practice in: _____

Address: _____ City: _____ Postal Code: _____ Province: _____

Phone #: _____ Fax #: _____ Email: _____

REFERRAL CHECKLIST:

☐ Referral form completed (Required) ☐ Additional Medical Documents supporting client diagnosis (Supplementary)

☐ Prescription and treatment history for anything not described on the referral form (Supplementary)

Physician Signature: _____ **Date** (M/D/Y): _____