MEDICAL CANNABIS ASSESSMENT & PLAN REFERRAL

GREENPATH
MEDICINAL HEALTH CENTRE

PHYSICIAN INFORMATION

Referring Physician	Phone #	Fax #

Referring Physician Prac ID #

PATIENT INFORMATION

Title: Mr ☐ Mrs ☐ Ms ☐ Miss ☐ | Sex: M ☐ F ☐ Uknown ☐

Last Name	First Name	Middle Name

Date of Birth (Month)	(Day)	(Year)

Email

Postal Address	City	Province	Postal Code

Preferred Method of Communication (cell phone, email, home phone, etc.)

Is Patient Palliative? Yes ☐ No ☐

Reason for Referral

Additional Comments

Physician Signature	Date