PHYSICIAN REFERRAL FORM

(p) 1.888.671.8022
(e) support@naturalcaregroup.com
www.naturalcaregroup.com
5255 Yonge St., Suite 1005
Fax to 888-735-9777

PATIENT NAME: _____ **DOB:** _____
FIRST MIDDLE LAST DD / MM / YYYY

PHONE #: HOME _____ CELL _____ WORK _____

ADDRESS: _____

HEALTH CARD: _____ **EMAIL:** _____

REASON FOR REFERRAL:

[ ] Assess suitability for cannabinoid therapy [ ] Other: _____

DIAGNOSIS:

[ ] Chronic Pain [ ] Sleep Disorder [ ] Cancer [ ] Gastrointestinal

[ ] Anxiety [ ] Fibromyalgia [ ] Arthritis [ ] Multiple Sclerosis

[ ] PTSD [ ] Depression [ ] Other: _____

CURRENT MEDICATION(S):

_____

PREVIOIUS CANNABINOID USE: [ ] Nabilone [ ] Sativex [ ] Cannabis

REFERRING PHYSICIAN:

*** PLEASE SEND ALL PERTINENT MEDICAL RECORDS PERTAINING TO MAIN DIAGNOSIS INCLUDING RECENT CONSULTATIONS WITH SPECIALISTS AND DIAGNOSTIC IMAGING REPORTS.

NAME (Print): _____ **DATE:** _____
DD / MM / YYYY

ADDRESS: _____

PHONE: _____ **FAX:** _____

EMAIL: _____ **BILLING #:** _____

SIGNATURE: _____