NATURAL CARE

REFERRAL FORM
HEALTHCARE PROFESSIONALS

FAX: 647.362.3367
1.888.671.8022
support@naturalcaregroup.com
www.naturalcaregroup.com
5255 Yonge St., Suite 1111 | Toronto, ON

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

PHONE #: HOME _____ CELL _____ WORK _____

ADDRESS: _____

HEALTH CARD #: _____ **EMAIL:** _____

POWER OF ATTORNEY (POA) CONTACT INFORMATION. COMPLETE THIS SECTION ONLY IF APPLICABLE.

POA NAME _____ **POA EMAIL**_____

POA HOME PHONE #_____ **POA CELL #**_____

POA ADDRESS_____

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): _____

PREVIOUS CANNABINOID USE: ☐ Nabilone ☐ Sativex ☐ Cannabis

REFERRING HEALTHCARE PROFESSIONAL OR ADMINISTRATOR TO FILL.

***** PLEASE FAX MEDICAL RECORDS PERTAINING TO MAIN DIAGNOSIS, INCLUDING (e)MAR, IF APPLICABLE.**

NAME:_____ **DATE:** _____

ADDRESS: _____

PHONE: _____ **FAX:** _____

EMAIL: _____ **BILLING # (NOT REQUIRED):** _____

YOUR PROFESSIONAL DESIGNATION(S): _____

A healthier way to happiness.