Physician Referral Form

Ph: 604-559-8022
Fax: 604-428-8977
www.allacessmedicalclinic.com

Patient Name: ______________________________

Date of Birth: ______________________________

Address: ______________________________

____

Contact Tel: ______________________________

❑ **Medicinal Cannabis Education Only**

❑ **Medicinal Cannabis Authorization**

❑ **Medicinal Cannabis Assessment**

Please fax/provide the following additional clinical information:

1. Copy of any relevant reports / Letter from consulting specialist

2. Diagnosis/Reason for Referral:

____

____

3. Treatments tried to date:

____

____

4. Current medications:

____

____

5. Past Medical History

____

____

Physician Signature: ______________________________

Physician Name: ______________________________

License Number: ______________________________

Date: dd/mm/yyyy ______________________________

Practitioner address: ______________________________

____

Tel: ______________________________

Fax: ______________________________

All Access Medical Clnic
1710 West 4th Ave, Vancouver, BC
V6J 1M1