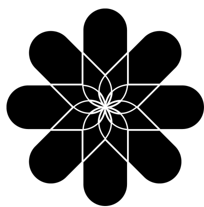

CANNABIS
TREATMENT
CLINIC

Referral - Medical Cannabis Assessment

Fax to 1-888-731-6269 (or info@ctclinic.ca)

Patient Information

FIRST and LAST NAME		DOB (DD/MM/YYYY)	
HEALTH CARD # (include version code)/K# (if veteran)			
ADDRESS			

CITY		PROVINCE		POSTAL CODE	
TELEPHONE	Home#		Mobile#		

Follow up instructions:
Can a voice message be left at this number to schedule an appointment? YES ☐ NO ☐
Patient Caretaker who can be contacted, if applicable:

Health Information

PRIMARY COMPLIANT

TREATMENT/MEDICATION USED:

PATIENT DIAGNOSIS AND SYMPTOMS

Does the patient have any UNCONTROLLED mania, schizophrenia, depression, using sedatives/hypnotics/other psychoactive drugs? YES ☐ NO ☐

IMPORTANT: Fax recent investigation & consultation reports to 1-888-731-6269

Referring Physician Information

FULL NAME		BILLING #	
TELEPHONE		FAX	
Physician Signature		**Date**	

Your patient will be contacted directly to schedule an appointment.
A consultation report will be provided after the appointment.

Forms can be sent via email or fax
info@ctclinic.ca 1-888-731-6269

Any Questions
416-297-7762 www.ctclinic.ca