Referral Form

Please Fax to (613) 729-9065
OR
Email to: InHome@NationalAccessCannabis.com

Patient Information

Name: ______________________________________

Health Card #: ____

Street Address: ______________________________________

Telephone #: ____

City/Province/Postal Code: ______________________________________

Date of Birth (MM/DD/YYYY): ____

Can a voice message be left at this number to schedule an appointment? Yes ◯ No ◯

Patient Diagnosis and Symptoms:

____

____

Current Treatments/Medications:

____

____

Previously Used Treatments/Medications:

____

____

Other Relevant Medical Information:

____

____

Reminder Checklist

◯ (Required)
Referral form completed by Licensed Physician

◯ (Supplementary)
Additional Medical Documents supporting client diagnosis

◯ (Supplementary)
Prescription and treatment history for anything not described on the Referral Form

A consultation appointment will be scheduled once ALL the requested information has been received and reviewed.

Referring Physician: ______________________________ Provincial Billing #: ____________________

Address: ____

Telephone: (_____) _____ - ________ Fax: (_____) _____ - ________

Signature: _________________________________ Date (MM/DD/YYYY): _____ / _____ / _____

let's talk **answers**

ADDRESS: 1111 WELLINGTON ST. W. OTTAWA, ON. **PHONE**: 1-800-411-1126 **FAX:** (613) 729-9065 **EMAIL:** INHOME@NATIONALACCESSCANNABIS.COM