CVCC

Email complete package to
registration@curavidacannabisclincs.com

Refer to: _____

REFERRAL FORM

PATIENT INFORMATION

Patient's Name: _____ DOB: _____ (MM/DD/YYYY) Gender: _____

Patient's Address: _____ Phone: _____

Health #: _____ Health Card Expiry: _____ (MM/DD/YYYY)

E-mail: _____ Date: _____ (MM/DD/YYYY)

Reason for Assessment: ☐ Pain ☐ Anxiety ☐ Sleep ☐ Depression ☐ Cancer ☐ Fibromyalgia ☐ PTSD ☐ Other

Current medical conditions (please provide a copy of medical records, including consults + prior treatments and list any current medication)

☐ History of Bipolar
☐ History of Schizophrenia
☐ History of Psychosis

REFERRING HEALTHCARE PROFESSIONAL

_____ _____ _____

Healthcare Professional name (print) Healthcare Professional signature

Healthcare Professional phone: _____ Fax: _____

Address: _____ E-mail: _____