Referral Form

Toll Free Phone: 1 (888) 282 7763
Toll Free Fax: 1 (844) 320 9652
Visit us online
cmclinic.ca

CANABO MEDICAL CORP

Patient Information:

Name:_____ Date of Birth: _____ (MM/DD/YYYY) Health Card # _____

Address: _____ City: _____ Postal Code:_____

Phone: (H) _____ (C) _____ (W) _____ Email: _____ (REQUIRED)

Reason for Referral:

- ☐ Chronic pain
- ☐ Cancer (please specify)_____
- ☐ Immunological condition (please specify)_____
- ☐ Neurodegenerative disease (please specify)_____
- ☐ Multiple sclerosis (pain/spasticity)
- ☐ Epilepsy
- ☐ Anxiety
- ☐ Insomnia
- ☐ PTSD
- ☐ Other _____

Does Patient Have:

☐ Schizophrenia/psychosis) ☐ Unstable cardiac disease ☐ Ongoing substance abuse

Are you a member of a FHO/FHN/FHT? (Ontario Physicians ONLY) ☐ Yes ☐ No

Referring Physician / Referral Source:

Name (Please Print): _____ Billing Number: _____

Address: _____

Phone Number:_____ Fax Number: _____

Email Address: _____ Signature: _____

Please select clinic location:

☐ Alberta ☐ Newfoundland & Labrador ☐ Ontario

☐ British Columbia ☐ Nova Scotia