421 Montgomery Street,
Fredericton, NB E3B 2X6

Medical Cannabis Education Program Referral Form

Please complete in full and return by mail or fax to (506) 454-7164

Date: __/__/____
DD MM YYYY

Referring Healthcare Provider Information:

Provider Name: _____

Profession/Specialty: _____

Phone/Email: _____

Fax: _____

Office Address: _____

_____

Original medical document was: □ sent with patient □ mailed with referral

Patient Information:

Patient Name: _____ DOB: __/__/____
DD MM YYYY

Phone or Email: _____

Address: _____

_____

Please disclose any of the following:

Special Considerations (ie: learning barriers; frail elderly; cognitive impairment; allergies or other risk factor):

_____

_____

_____

_____

_____

_____