FAX

Greenleaf
MEDICAL CLINIC

Suite 401 505-8840 210 St
Langley, BC V1M 2Y2
www.greenleafmc.ca

TO: +19725329272	**Date:** 02/17/2026
From: Greenleaf Medical Clinic	**Phone:** (604) 371-4769
Fax: (604) 371-2044	**Pages:** 3

Comments

Attached: Referral information – Greenleaf Medical Clinic Test

Greenleaf
MEDICAL CLINIC

Dear Clinic Team,

Since 2011, Greenleaf has been supporting patients across Canada through independent medical cannabis assessments.Today, we are one of Canada's longest-standing and most trusted virtual medical cannabis clinic.

How Greenleaf Supports Your Patients

- Medical cannabis assessments by licensed clinicians
- Evidence-informed guidance aligned with Canadian regulations
- Ongoing patient monitoring and education
- Secure access to federally licensed producers
- No cost to the referring clinic

Referral Process

Referring a patient is simple:

1. Provide the patient with our clinic information
2. Refer directly on our website *https://greenleafmc.ca/refer-a-patient*
3. Fill out the attached referral form and fax it back to us

We do not alter or replace a patient's primary care. Greenleaf Medical operates as an adjunct service, and patients are encouraged to maintain ongoing care with their existing healthcare providers.

If you would like additional information for your team or patients, please contact us at info@greenleafmc.ca

Sincerely,

Fonda Betts
Master Cannabinologist and CEO
Greenleaf Medical
www.greenleafmc.ca

Greenleaf MEDICAL CLINIC

PATIENT REFERRAL FORM

☐ URGENT ☐ SEMI-URGENT

Suite 401 505-8840 210 St
Langley, BC V1M 2Y2
t: (604) 371-4769
f: (604) 371-2044
www.greenleafmc.ca

PHYSICIAN INFORMATION

Referring Physician:	Phone:	Fax:
Billing #:		
Family Physician:	Phone:	Fax:

PATIENT INFORMATION

Last Name:	First :	Middle:	Sex: ☐ M ☐ F
Date of Birth: (dd/mm/yyyy)	Personal Health Number:		
Address:	City:	Province:	Postal Code:
Home Phone:	Cell Phone:	Email:	

PATIENT MEDICAL HISTORY

MENTAL HEALTH CONDITIONS

☐ ADD/ADHD
☐ Anxiety
☐ Autism/Developmental Delay
☐ Bi-Polar
☐ Depression
☐ Eating Disorder
☐ PTSD
☐ Sleep Disorder
☐ Schizophrenia

GASTROINTESTINAL CONDITIONS

☐ Appetite
☐ Colitis
☐ Crohn's Disease
☐ Hepatitis
☐ Irritable Bowel Syndrome
☐ Nausea

NEUROLOGICAL/PAIN CONDITIOINS

☐ Alzheimer's Disease
☐ Arthritis-Osteoarthritis
☐ Arthritis-Rheumatoid Arthritis
☐ Back & Neck Pain
☐ Bladder Pain
☐ Brain/Head Injury/Concussion
☐ Central Sensitivity Syndrome
☐ Chronic Pain/Neuropathic Pain
☐ Complex Regional Pain Syndrome
☐ Degenerative Disc Disease
☐ Epilepsy/Seizures
☐ Fibromyalgia
☐ Glaucoma
☐ Jaw Pain
☐ Migraines
☐ Muscle Spasms
☐ Parkinson's Disease
☐ Pelvic Pain/Endometriosis
☐ Post Surgical Pain
☐ PMS/Menstrual Cramps
☐ Repetitive Strain Injury
☐ Spinal Cord Injury/Disease
☐ Trauma

CANCER CONDITIONS

☐ Appetite
☐ Cancer
☐ Nausea
☐ Pain

MISC./OTHER CONDITIONS

☐ Chronic Fatigue Syndrome
☐ Fatigue
☐ Other
☐ HIV/AIDS
☐ Libido
☐ Menopause
☐ POTS

Please select medication that has been tried:

☐ Gabapentin/Lyrica ☐ Muscle Relaxants ☐ Opioids ☐ NSAIDs ☐ SSRIs
☐ IV Lidocaine ☐ IV Ketamine ☐ Nabilone ☐ Tramadol ☐ Amitriptyline/Nortriptyline

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

DO SEND: List of medications. Any injury or disease relevant imaging such as XRay, CT, MRI etc. As well as relevant consults (psych, neuro, rheum and surgical.) **DO NOT SEND**: Bloodwork results.

Other Medical History:

Email referral to: fax@greenleafmedicalclinic.ca OR Fax referral to 1-604-371-2044

Physician Signature: **Date:**