



B & B Medical Marijuana Evaluation Center

REFERRAL FORM

Fax Form to: 401-921-5829

Date: _____

Patient Name: _____

DOB (D/M/Y) _____

Phone: _____

Address: _____

OHIP: _____

Primary Diagnosis _____

Secondary Diagnosis _____

List of current medications (Can attach list)

Referring Physician (**office stamp accepted**)

Name: _____

Address: _____

Phone: _____

B & B Consulting, LLC, dba B & B Medical Marijuana Eval Cntr - 300 Toll Gate Rd, Suite 201 - Warwick, RI 02886

Phone: 401-921-5791 / Fax: 401-921-5829

Info@BandBConsultingRI.com

[HTTP://www.BandBConsultingRI.com](http://www.BandBConsultingRI.com)

Please provide our office with the following information:

-Pertinent copy of medical records including doctor/office notes, imaging reports, relevant consultations, etc. for the last two years (24 months).

All referrals will be processed in the order they are received.

Your patient will be contacted directly for their appointment date and time.

Any questions, please contact our office.

Thank You,

B&B Medical Marijuana Evaluation Center

300 Toll Gate Road, Suite 201

Warwick, RI 02886

Phone: 401-921-5791

Fax: 401-921-5829

E-mail: info@bandbconsultingri.com