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

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

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