9-6975 Meadowvale Town Circle, Suite #111
Mississauga, ON L5N 2V7

289-499-2596 289-335-4696

Medical Document

This medical document is to be completed by a Prescribing Healthcare Practitioner

Section 1: Patient Information

Patient Name: ____

First Name Last Name

Date of Birth: (MM/DD/YY) _________/__________/_______ Telephone: (_____) _________- __________

Email: ___________________________________ Medical Diagnosis: ____

Written Order:

The maximum quantity of dried cannabis a patient may possess cannot exceed 30 times the daily amount prescribed, or 150 grams (whichever is the Lesser) as per the Access for Medical Purpose Regulations(ACMPR)

☐Number of grams per day: _______ grams. ☐Specify Type of Cannabis(Optional): ___________________________

☐Duration of Prescription: _______ months (maximum 12 months) ☐Prescriber Instructions (Optional): _____________________________

Section 2: Physician Information

Name: ___________________________________ ________________________________

First Name Last Name

Profession: ___________________ Medical License #: _____________ Province: ________

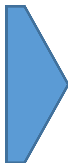
Phone # ____________________ Fax # _______________________

Health Care Practitioner's Business address

Or

Business address of the location at which the

Patient consulted the practitioner (if Different)



Note: Stamp or Sticker Here

Section 3: Consultation Address (the address at which the consultation took place)

Check one of the following:

☐ The consultation took place at the business address as stated above, via telemedicine or in person.

☐ The consultation took place via telemedicine

I _____________________________________ attest that the information contained in this document is correct and complete.

Print name of prescribing Healthcare Practitioner full name

Signature of Prescribing Healthcare Practitioner: _______________________________________ **Date: (MM/DD/YY)** ____/_______/_______

Practitioner Initials: INITIAL HERE IF YOU ARE SUBMITTING THIS MEDICAL DOCUMENT TO A LICENSED PRODUCER VIA FAX:

I have chosen to submit the original Medical Document to the licensed producer via secure fax. I acknowledge that the faxed Medical Document is now the original Medical Document and that I have retained a copy of this document for my records only.

Send completed document to fax number: 289-335-4696