HEALTH CANADA MEDICAL DOCUMENT (PRESCRIPTION) **FAX TO 905-286-4450**

ACCESS TO CANNABIS FOR MEDICAL PURPOSES REGULATIONS (ACMPR)

HEALTH CARE PRACTITIONER INFORMATION

GIVEN NAME:_____ SURNAME: _____

TITLE/PROFESSION _____ MEDICAL LICENSE # _____

PROVINCE OF REGISTRATION: _____

CLINIC NAME: _____

ADDRESS: _____ CITY: _____ PROVINCE: _____
POSTAL CODE: _____PHONE: _____ FAX: _____

DID THIS CONSULTATION TAKE PLACE AT THE ABOVE ADDRESS: YES____ NO _____

IF "NO" PLEASE SPECIFY ADDRESS: _____

PATIENT INFORMATION

GIVEN NAME: _____ SURNAME _____

DATE OF BIRTH: MONTH _____ DAY _____ YEAR _____ GENDER: M ____ F ____

ADDRESS: _____ APT: _____ CITY: _____

PROVINCE: _____ POSTAL CODE _____

TELEPHONE: _____ EMAIL: _____

MEDICAL DIAGNOSIS (optional) _____

Grams per day _____ for _____ months (period of use cannot exceed 12 months)

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

Health Care Practitioners Signature x _____

DATE:(DD/MM/YYYY) _____/_____/_____

I acknowledge that the faxed medical document is now the original medical document and that I have retained a copy for my records only- Initial _____