

Medical Document

This medical document is to be completed by an Authorizing Health Care Practitioner (HCP).

FAX TO: (306) 952-1482

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Patient Information

(Please complete below or affix patient label)

Patient Name: _____

DOB (MM/DD/YYYY): _____

Telephone: _____
Home Mobile

Email: _____

Diagnosis: _____

AFFIX PATIENT LABEL

Authorization for Medical Cannabis

The maximum quantity of dried cannabis a patient may possess cannot exceed 30 times the daily amount authorized or 150 grams (whichever is the less) as per the Cannabis Act and its regulations.

Quantity (grams per day): _____ grams. [Mandatory Field]

Duration: _____ months (maximum 12 months). [Mandatory Field]

Limitations: [Optional] Oral Only [Optional] THC Limit _____ %

[Optional] Dried Flower Only [Optional] THC Limit _____ %

Authorizing Health Care Practitioner Information

Name: _____
First Name Last Name

Profession: Physician Nurse Practitioner Name of Office or Clinic: _____

Business Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone: _____ Fax: _____ Email: _____

Medical License Number: _____ Province(s) Authorized: _____

Consultation Method

The consultation was conducted through [check one and complete the field]:

An in-person visit: Business address of consultation with patient (if different than above):

Telemedicine. The Health Care Practitioner was located in the province of: _____

Declaration & Signature

By signing this document, the Healthcare Practitioner (HCP) is attesting that the information contained in this document is correct and complete. **I, the Healthcare Practitioner (HCP), am submitting the original Medical Document via secure fax.** I acknowledge that the securely faxed Medical Document is now the original Medical Document and that I have retained a copy of this document for my records only.

Signature of Authorizing HCP: _____ Date: (DD/MM/YYYY): _____

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Faxed to (office use only): _____ Faxed by (office use only): _____