

# Medical Document

To be completed by a Health Care Practitioner

All fields are required. Please print clearly

## Patient Information

Given Name: \_\_\_\_\_ Surname: \_\_\_\_\_

Date of Birth (DD/MMM/YYYY): \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Gender:  male  female  undisclosed

## Health Care Practitioner Information

Given Name: \_\_\_\_\_ Surname: \_\_\_\_\_

Profession: \_\_\_\_\_ License #: \_\_\_\_\_ Prov. Licensed to Practice: \_\_\_\_\_

Name of Clinic or Business (if applicable): \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_

E-mail (optional) : \_\_\_\_\_

Address of consultation if different than above

Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

STAMP

Required if applicable. Your Medical Document may be submitted to us by mailing the original version or by faxing a copy of the original. It may be sent to the address or fax number on the top left corner of this document depending upon your preferred method. If you choose to fax this document it must be faxed by your Health Care Practitioner from their business fax number.

Initials

### HEALTH CARE PRACTITIONER INITIAL IF YOU ARE SUBMITTING THE MEDICAL DOCUMENT TO ABCANN BY FAX

I, the patient's Health Care Practitioner have chosen to submit the original Medical Document via ABCann secure fax ePortal. I acknowledge that the faxed Medical Document is now the original Medical Document and the document in my possession reverts to a copy retained for record keeping purposes only.

Initials

### HEALTH CARE PRACTITIONER INITIAL IF YOU WILL BE RECEIVING THE PATIENT'S MEDICAL CANNABIS TO YOUR BUSINESS ADDRESS.

I, the Patient's Health Care Practitioner consents to receive medical cannabis on behalf of the patient at the business address on this Medical Document.

Note: If at anytime you cease to consent to receive medical cannabis on behalf of the Patient, you must send a written notice to that effect to both the Patient and the licensed producer.

Daily cannabis quantity: \_\_\_\_\_ grams, For: \_\_\_\_\_ days / weeks / months **(Please Indicate one)**

Medical Document cannot exceed one year and will commence the date the Medical Document is signed.

I, \_\_\_\_\_ attest that the information in this document is correct and complete.

(Print name of Health Care Practitioner)

Medical diagnosis (optional):

\_\_\_\_\_  
Signature of Health Care Practitioner

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date (DD/MMM/YYYY)

Preferred method to confirm this medical document:  By phone  By Fax  By Email  By Regular Mail