



Medical Document

To be completed by a prescriber for medical cannabis authorization.

Patient Information

Fields marked with ▶ are required. Information must match details on Patient Registration Form.

▶		▶		▶					
First Name	Last Name	Date of Birth (mm/dd/yyyy)	Gender						
▶									
Primary Phone Number	Email Address								
▶				▶	▶				
Diagnosis or Condition <small>(Optional except for patients seeking coverage through Veterans Affairs)</small>				Daily Quantity <small>(grams/day)</small>		Period of Use <small>Please note, period of use (in months) may not exceed 12</small>			

Optional Information for Product Selection

The MyMedi.ca cannabis care advisor or pharmacist will support the patient with selecting their own product

I have specific recommendations (e.g., producer, THC:CBD ratio, format, etc.) (please list)

Healthcare Professional Information

▶	▶	▶	▶
First Name	Last Name	Profession	Licence Number
▶		▶	
Authorized Province of Practice		Clinic Name	
▶		▶	▶
Clinic Address		City	Province
▶	▶	▶	▶
Postal Code	Telephone	Fax	Email
Method of Consultation		Location of Consultation <input type="checkbox"/> Same as above	
<input type="checkbox"/> In person	▶		▶
<input type="checkbox"/> Telemedicine	Address	City	Province
▶			
<input type="checkbox"/> I consent to receive medical cannabis products at my business address on behalf of this patient. Initial: _____			

I attest to the information in this medical document being correct and complete.

▶ _____ Date (mm/dd/yyyy)

Signature

If faxing directly to MyMedi.ca, 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.

▶ _____

Initials