MEDICAL DOCUMENT

Vitalicann

To be completed by a prescriber for medical cannabis authorization.

1. Patient Information

Name: _____ _____
(GIVEN NAME) (SURNAME)

Date of Birth: _____ **Gender:** ☐ Male
(DD/MM/YY) ☐ Female
☐ Prefer not to Disclose

Telephone: _____ **Email:** _____

Diagnosis: _____

Daily Quantity: _____ **Period of Use:** _____
(GRAMS/DAY) (PERIOD NOT TO EXCEED 12 MTHS)

☐ I HAVE SPECIFIC RECOMMENDATIONS: _____
(E.G. PRODUCER, THC:CBD RATIO, FORMAT ETC)

MANDATORY IF SELECTED

2. Healthcare Professional Information:

Name: _____ _____ _____
(TITLE) (GIVEN NAME) (SURNAME)

Clinic/Business Name: _____

Address: _____

_____

City: _____ **Province:** _____ **Postal Code:** _____

Telephone: _____ **Fax:** _____

Email: _____ **License Number:** _____

Method of Consultation: **Location of Consultation:** ☐ **Same as above**

☐ **In person** ☐ **Telemedicine**

ADDRESS: _____

☐ **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.

Signature: _____ **Date:** _____

If faxing directly to Vitalicann, 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. _____
INITIAL

For more information:
1.844.762.1800| care@vitalicann.ca | vitalicann.ca
Fax 1.844.762.1802.