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Medical Document

PATIENT/CLIENT INFORMATION			
First Name:		Last Name:	
Date of Birth (MM/DD/YY):		Male <input type="checkbox"/>	Female <input type="checkbox"/> Prefer Not to Disclose <input type="checkbox"/>
Email:		Phone Number:	
Prescribed Grams of Medical Cannabis per day: _____ g/day		K#/VAC FILE: _____	
TOTAL Prescribed Grams Medical Cannabis per day: _____ g/day			
Period of Use _____		Days <input type="checkbox"/>	Months <input type="checkbox"/> Year <input type="checkbox"/>
Diagnosis:			
Recommended THC Level (applicable to dry and oil form) Maximum THC _____% No Restrictions <input type="checkbox"/>			
HEALTH CARE PRACTITIONER INFORMATION			
Full Name:		Profession:	
Clinic Name:			
Medical License Number:		Province of Registration:	
Business and Consultation Address:			
City:		Province:	Postal Code:
Telephone:		Fax:	
Appointment was completed: In Person <input type="checkbox"/>		Telemedicine <input type="checkbox"/>	Over the phone <input type="checkbox"/>
WRITTEN ORDER			
<i>Note: The maximum quantity of dried cannabis a client may possess cannot exceed the maximum regulatory daily amount, as per the Cannabis Act/Regulations. The period of use cannot exceed one year & will begin on the day that the document is signed by the health care practitioner.</i>			
I..... (Health Care Practitioner) attest that the information contained in this document is correct & complete.			
Healthcare Practitioner Signature: Date:			
If your patient chooses to access cannabis for medical purposes via a licensed producer, this medical document can be submitted from the healthcare practitioner's office to the licensed producer by secure fax. If you choose to submit the medical document by secure fax, initial the statement below to acknowledge the agreement.			
I, the healthcare practitioner, acknowledge that the faxed medical document is now the original medical document, and I have retained a copy for my records only. <input type="checkbox"/>			