Medical Document

Questions?
Email: info@redecanpharm.ca

To be completed by Health Care Practitioner

Call us to arrange pick up of completed documents

Mail or Courier Completed Documents To:
RedeCan Pharm P.O. Box 138
Ridgeville, Ontario L0S 1M0

HEALTH CARE PRACTITIONER

Name: | Title | Given First Name(s) | Surname (Last Name)

Profession: | Clinic Name

License #: | Medical License Number | Province Licensed to Practice

Contact: | Practitioner Phone Number | Practitioner Fax Number | Practitioner Email

Office Address: | Unit # | Street Address 1 | Street Address 2 (If Applicable)

City | Province | Postal Code

☐ Same as Office Address listed above

Address of Consultation | Unit # | Street Address 1 | Street Address 2 (If Applicable)

Province | Postal Code

APPLICANT (PATIENT) INFORMATION

Patient Name: | Given First Name(s) | Surname (Last Name) | Patient's Date of Birth

DATE: Day / Month / Year

WRITTEN ORDER FOR MEDICINAL MARIHUANA (CANNABIS)

*Note*a patient may NOT possess more than 150 grams, or 30 times the prescribed daily amount, whichever is smaller.

Medical Diagnosis: (Optional)

# of grams | per day for # of Days | OR Month(s) (Max of 1 year)

grams | # days | # months

Note the *period of use* cannot exceed 1 year & will commence from the date signed below.

I | attest that the information contained herein is correct & complete.

Name of Health Care Practitioner

Health Care Practitvioner's Signature: _____

DATE: Day / Month / Year

☐ Verification completed