RedeCan Medical Document

To be completed by Health Care Practitioner

Questions?
Email: info@redecan.ca

Return Completed Forms via:
Secure Fax: 905-892-6711
Mail: PO Box 138
Ridgeville, ON
L0S 1M0

HEALTH CARE PRACTITIONER INFORMATION

Name:
Title *Given First Name(s)* *Last Name*

Profession: Clinic Name:

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

Contact:
Practitioner Phone Number *Practitioner Fax Number* *Practitioner Email*

Business Address:
Unit # *Street Address 1* *Street Address 2 (if applicable)*
City *Province* *Postal Code*

☐ Same as Business Address listed above

Consultation Address:
Unit # *Street Address 1* *Street Address 2 (if applicable)*
City *Province* *Postal Code*

☐ The health care provider listed above consents to receive cannabis products from RedeCan on behalf of the patient.

Applicant (Patient) Information

Patient Name:
Given First Name(s) *Last Name* *Date of Birth: Day / Month / Year*

Patient Contact:
Email *Mailing Address*

Written Order for Medicinal Cannabis

NOTE: A patient may NOT possess more than 150 grams, or 30 times the prescribed daily amount, whichever is smaller.

Medical Diagnosis:
(Optional)

Prescribing: ____ per day, for ____ **OR** ____ THC Max *(Optional)* ____
# of grams *# of days* *# of months* *% or mg/ml*

NOTE: The period of use/duration cannot exceed 1 year & will commence from the date signed below.

I ____ **attest that the information contained herein is correct and complete.**
Name of Health Care Practitioner

Health Care Practitioner's Signature:

DATE: Day / Month / Year