MEDICAL DOCUMENT

This form must be completed by a Health Care Practitioner who is fully licensed in Canada.
If another document is used instead of this one, please ensure all information below is included.

Phone: 1-888-759-2552
Secure Fax: 1-877-886-2754
Address: 5705-99 Street NW, Edmonton, AB, T6E 3N8

HEALTH CARE PRACTITIONER INFORMATION

PRACTITIONER TITLE

PRACTITIONER FIRST NAME

PRACTITIONER LAST NAME

MEDICAL PROFESSION

MEDICAL LICENSE #

PROVINCE(S) AUTHORIZED TO PRACTICE

BUSINESS ADDRESS

CITY

PROVINCE

POSTAL CODE

PHONE NUMBER

FAX

EMAIL ADDRESS

ADDRESS OF CONSULTATION

If different from above, please enter the address where the consultation took place.

BUSINESS ADDRESS

CITY

PROVINCE

POSTAL CODE

PATIENT INFORMATION

PATIENT FIRST NAME

PATIENT LAST NAME

DATE OF BIRTH (MM / DD / YYYY)

PHONE NUMBER

EMAIL ADDRESS

GENDER

○ MALE ○ FEMALE ○ OTHER

PRESCRIPTION

NUMBER OF GRAMS / DAY

DURATION OF USE (MAXIMUM OF 365 DAYS)

○ DAYS ○ WEEKS ○ MONTHS

MEDICAL DIAGNOSIS (OPTIONAL)

I attest that the information contained in this document is correct & complete. If submitted by fax, I acknowledge the faxed document is now the original medical document and that this document will be deemed a copy, retained for my records only.

SIGNATURE OF HEALTH CARE PRACTITIONER

DATE (MM / DD / YYYY)