hybridpharm

MEDICAL DOCUMENT
(Your Prescription)

318 Richmond Road – Ottawa, ON – K1Z 6X6
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PATIENT INFORMATION

First Name(s): _____ Last Name: _____

Birth Date: [M]_____ [D]_____ [Y]_____ Gender: ☐ Male ☐ Female ☐ N/A

Health Card #: _____ *(Veterans please enter K#) Exp:* _____

Phone #: _____ Email: _____

Drug Allergies: ☐ NKDA
☐ Yes *(please specify)*: _____ _____

Rx

Diagnosis: _____

Daily Quantity:
# of dried g/day (check one box)
☐ 1g ☐ 2g ☐ 3g ☐ 4g ☐ 5g ☐ Other: _____

Dosage Form: *(optional)*
☐ Oil ☐ Dried ☐ Both

Expires After:
(check one box Max - 365 days)
☐ 60 days ☐ 90 days ☐ 120 days ☐ 150 days ☐ 180 days ☐ 365 days ☐ Other: _____

Strength: *(optional)*
_____ % of CBD
% of THC

HEALTH CARE PRACTITIONER INFORMATION

First Name(s): _____ Last Name: _____

Profession: _____ License #: _____ Province Authorized to Practice in: _____

Address: _____ City: _____ Postal Code: _____ Province: _____

Phone #: _____ Fax #: _____ Email: _____

Consultation Address: ☐ Hybrid Pharm ☐ Address Above ☐ Other: _____
_____
_____

By signing this document, the health care practitioner is attesting that the information contained in this document is correct and complete.

Signature: _____ **Date** (M/D/Y)**:** _____