HYBRID PHARM™
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Medical Document

Patient Information

First Name(s): _____

Last Name: _____

Birth Date: _____

Gender: ◯ Male ◯ Female ◯ N/A

Health Card #: _____

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

Affix Patient Label or Stamp here

Phone #: _____ **Email:** _____

Drug Allergies: ◯ NKDA ◯ Yes (please specify): _____

Diagnosis: _____

Daily Quantity: ◯ 1g ◯ 2g ◯ 3g ◯ 4g ◯ 5g **Other:** _____
# of dried gram per day

Duration in Days: ◯ 60 ◯ 90 ◯ 120 ◯ 150 ◯ 180 ◯ 365 **Other:** _____
365 days maximum

Special Considerations: _____
Dosage form, limitations, dose, etc.

Health Care Practitioner Information

First Name(s): _____ **Last Name:** _____

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

Address: _____ **City:** _____ **Postcode:** _____ **Province:** _____

Phone #: _____ **Fax:** _____ **Email:** _____

Consultation Method: ☐ In-Person ☐ Telemedicine **Name of Office or Clinic:** _____

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

Physician Signature : _____

Date (M/D/Y): _____