

**Patient Information**

**First Name(s):** \_\_\_\_\_

**Last Name:** \_\_\_\_\_

**Birth Date:** \_\_\_\_\_

**Gender:**  Male  Female  N/A

**Health Card #:** \_\_\_\_\_

**Exp:** \_\_\_\_\_ (Veterans please enter K#)

**Phone #:** \_\_\_\_\_

**Email:** \_\_\_\_\_

**Drug Allergies:**  NKDA  Yes (please specify): \_\_\_\_\_

*Affix Patient Label or Stamp here*

**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):** \_\_\_\_\_