NATIONAL ACCESS CANNABIS

Medical Document

This medical document is to be completed by a Prescribing Physician.
This medical document MUST be faxed to (204) 615-8979.

Patient Information

Patient Name: _____ _____
First Name Last Name

Date of Birth: (MM/DD/YY) _____ / _____ / _____ Telephone: (_____) _____ - _____

Email: _____ Diagnosis: _____

Prescription

*The maximum quantity of dried cannabis a patient may possess cannot exceed 30 times the daily amount prescribed, or 150 grams (whichever is lesser) as per the Access to Cannabis for Medical Purposes Regulations (ACMPR). * = Mandatory field*

◯ Number of grams per day: _____ grams *

◯ Duration of prescription: _____ months (maximum 12 months) *

◯ Prescriber Instructions (Optional): _____

Prescribing Physician Information

Name: _____ _____
First Name Last Name

Profession: _____ Name of office or Clinic: _____

Business Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone: (____) ____ - _____ Fax: (____) ____ - _____ Email: _____

Medical License Number: _____ Province(s): _____

Consultation Address: (the address at which the consultation took place)

Check one of the following:

◯ The consultation took place at the business address as stated above, via telemedicine or in person.

◯ The consultation took place via telemedicine or in person at 379 Broadway, Unit 101, Winnipeg, MB, R3C 0T9.

I _____ attest that the information contained in this document is correct and complete.
Printed name of Prescribing Physician

I choose to submit the original medical document via secure fax. I acknowledge that the secure faxed Medical Document is now the original Medical Document and that I have retained a copy of this document for my records only.

Signature of Prescribing Physician: _____ Date: (MM/DD/YY) _____ / _____ / _____

let's talk answers