Medical Document

This medical document is to be completed by a Prescribing Physician.

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).

- ◯ 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 210 2nd Avenue North, Saskatoon SK

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

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

let's talk **answers**