ABcann MEDICINALS

PO Box 157, Napanee Ontario K7R 3M3
www.ABcann.ca

T +1-855-322-2266
F +1-855-235-6048

Medical Document

To be completed by a Health Care Practitioner

All fields are required. Please print clearly

Patient Information

Given Name:_____ Surname:_____

Date of Birth (DD/MMM/YYYY): _____/_____/_____ Gender: ☐ male ☐ female ☐ undisclosed

Health Care Practitioner Information

Given Name: _____ Surname: _____

Profession: _____ License #: _____ Prov. Licensed to Practice: _____

Name of Clinic or Business *(if applicable)*: _____

Address: _____ City: _____

Province: _____ Postal Code: _____

Phone: (_____) _____ Fax: (_____) _____

E-mail *(optional)* : _____

STAMP

Address of consultation if different than above

Address:_____

City: _____ Province: _____ Postal Code: _____

Required if applicable. Your Medical Document may be submitted to us by mailing the original version or by faxing a copy of the original. It may be sent to the address or fax number on the top left corner of this document depending upon your preferred method. If you choose to fax this document it must be faxed by your Health Care Practitioner from their business fax number.

Initials ☐

HEALTH CARE PRACTITIONER INITIAL IF YOU ARE SUBMITTING THE MEDICAL DOCUMENT TO ABCANN BY FAX
I, the patient's Health Care Practitioner have chosen to submit the original Medical Document via ABcann secure fax ePortal. I acknowledge that the faxed Medical Document is now the original Medical Document and the document in my possession reverts to a copy retained for record keeping purposes only.

Initials ☐

HEALTH CARE PRACTITIONER INITIAL IF YOU WILL BE RECEIVING THE PATIENT'S MEDICAL CANNABIS TO YOUR BUSINESS ADDRESS.
I, the Patient's Health Care Practitioner consents to receive medical cannabis on behalf of the patient at the business address on this Medical Document.
Note: If at anytime you cease to consent to receive medical cannabis on behalf of the Patient, you must send a written notice to that effect to both the Patient and the licensed producer.

Daily cannabis quantity: _____ grams, For: _____ days / weeks / months **(Please Indicate one)**

Medical Document cannot exceed one year and will commence the date the Medical Document is signed.

I, _____ attest that the information in this document is correct and complete.

(Print name of Health Care Practitioner)

Medical diagnosis ***(optional)***:

_____
Signature of Health Care Practitioner

_____/_____/_____
Date (DD/MMM/YYYY)

Preferred method to confirm this medical document: ☐ By phone ☐ By Fax ☐ By Email ☐ By Regular Mail