CANNA FARMS™ MEDICAL

MAIL OR FAX COMPLETED FORM TO:
CANNA FARMS LIMITED
Address: P0 Box 1419, Hope B.C., V0X 1L0
Fax completed form to: 1-855-244-9158
CONTACT US:
Phone: 1-855-882-0988
Email: care@cannafarms.ca

MEDICAL DOCUMENT

To be completed by a Health Care Practitioner. All mandatory fields have been marked with asterisk (*)

HEALTH CARE PRACTITIONER INFORMATION

Title | Given Name* | Last Name*

Profession ☐ Physician ☐ Nurse Practitioner ☐ Specialty _____

Preferred Method of Contact* ☐ Phone ☐ Fax ☐ Email

Business/Clinic Name* | Address*

Phone* | Fax* | Email*

Consultation Address (if different from clinic address)* | Province of Practice* | License Number*

PATIENT INFORMATION

Title | Given Name* | Last Name*

Date of Birth* (MM/DD/YYYY) | Phone | Email

AUTHORIZATION FOR MEDICAL CANNABIS

WRITTEN ORDER*

Medical Diagnosis
(Primary condition required if document will be submitted to Veterans Affairs)

NUMBER OF GRAMS PER DAY* ☐

FOR* ☐ Days ☐ Weeks ☐ Months

Note: The period of use cannot exceed 12 months and will commence from the date the document is registered with Canna Farms.™

I*, _____

hereby attest that the information contained herein is correct and complete.*

X _____ (Signature of Health Care Practitioner*) | Date* (MM/DD/YYYY)

RECOMMENDED CANNABIS-BASED PRODUCT

DOSAGE FORMAT
☐ Oils ☐ Soft Gel Capsules ☐ Dried Flower
☐ Topicals ☐ Sprays ☐ Concentrates
☐ Vape Pens ☐ Edibles
☐ Other _____

CANNABINOID ☐ THC-dominant ☐ CBD-dominant ☐ Balanced

MAXIMUM THC (% OR mg/ml) (Optional) ☐

Nature of recommendation ☐ Suggestion ☐ Mandate

Additional instructions (if any)

☐ By initialing this box, I, the supporting Health Care Practitioner, have been asked by my patient to send this medical document directly to a licensed seller. In sending it by fax, I acknowledge that the faxed medical document shall constitute the original medical document. Health Care Practitioner also attests that this Medical Document will not be faxed or provided to any other party.