

MEDICAL DOCUMENT

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

MAIL OR FAX COMPLETED FORM TO:

CANNA FARMS LIMITED

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HEALTH CARE PRACTITIONER INFORMATION Title Given Name* Last Name* Profession Physician Nurse Practitioner Preferred Method of Contact* Specialty 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) Email **AUTHORIZATION FOR MEDICAL CANNABIS RECOMMENDED CANNABIS-BASED PRODUCT WRITTEN ORDER* Medical Diagnosis DOSAGE** Oils Soft Gel Capsules Dried Flower (Primary condition required if document will be submitted to Veterans Affairs) **FORMAT** Topicals Sprays Concentrates ☐ Vape Pens ☐ Edibles

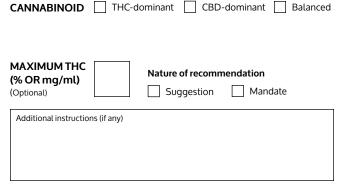
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FOR*

Davs

Weeks

Months



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NUMBER OF

GRAMS PER DAY*







Other



