Medical Document

To be completed by a healthcare professional for the purposes of medical cannabis authorization. If you require any assistance please call 250.883.0417

FIRST CHOICE CANNABIS

PATIENT INFORMATION:

First Name	Last Name	Gender (M,F, Other)	Date of Birth (YYYY/MM/DD)

HEALTHCARE PROVIDER INFORMATION:

First Name	Last Name	Profession	License / Registration Number

Province of Registration	Business Address (Street / Suite Number / City / Province / Postal Code)

Location of Consultation (If different than business address) (Street / Suite Number / City / Province / Postal Code)

Contact Information: (Please fill each field, and check off your preferred method.)

☐ Email	☐ Phone	☐ Fax

AUTHORIZED DOSAGE OF DRIED MEDICAL CANNABIS:

Quantity (grams per day)	Duration (maximum 1 year):
	_____ ☐ Days ☐ Weeks ☐ Months
Product Recommendations (optional):	Patient Diagnosis (optional):
	_____ ☐ Days ☐ Weeks ☐ Months
Additional Comments:	

I hereby certify that the information in this document is correct and complete. In addition, I agree that the faxed Medical Document now becomes the original Medical Document, and that I have retained a copy of this document for my records only.

Signature of Healthcare Practitioner	Date: (YYYY/MM/DD)

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