RedeCan Medical Document

To be completed by Health Care Practitioner

Questions?
Email: info@redecan.ca

Return Completed Forms via:
Secure Fax: 905-892-6711
Mail: PO Box 138
Ridgeville, ON
L0S 1M0

HEALTH CARE PRACTITIONER INFORMATION

Name: | *Title* | *Given First Name(s)* | *Last Name*

Profession: | Clinic Name:

License #: | *Medical License Number* | *Province Licensed to Practice*

Contact: | *Practitioner Phone Number* | *Practitioner Fax Number* | *Practitioner Email*

Business Address: | *Unit #* | *Street Address 1* | *Street Address 2 (if applicable)*

City | *Province* | *Postal Code*

☐ Same as Business Address listed above

Consultation Address: | *Unit #* | *Street Address 1* | *Street Address 2 (if applicable)*

City | *Province* | *Postal Code*

☐ The health care provider listed above consents to receive cannabis products from RedeCan on behalf of the patient.

Applicant (Patient) Information

Patient Name: | *Given First Name(s)* | *Last Name* | *Date of Birth: Day / Month / Year*

Patient Contact: | *Email* | *Mailing Address*

Written Order for Medicinal Cannabis

NOTE: A patient may NOT possess more than 150 grams, or 30 times the prescribed daily amount, whichever is smaller.

Medical Diagnosis: *(Optional)*

Prescribing: | *# of grams* | per day, for | *# of days* | **OR** | *# of months* | THC Max *(Optional)* | *% or mg/ml*

NOTE: The period of use/duration cannot exceed 1 year & will commence from the date signed below.

I | *Name of Health Care Practitioner* | **attest that the information contained herein is correct and complete.**

Health Care Practitioner's Signature:

DATE: Day / Month / Year