Website: www.cannalogue.ca
Phone: 1-833-226-6248
Email: registrations@cannalogue.ca
Secure Fax: 1-833-295-5133
Address: P.O. Box 94 Stn Don Mills, North York, ON, M3C 2R6

CANNALOGUE

Cannalogue Medical Document

Instructions for a Healthcare Practitioner: Complete the Cannalogue Medical Document and have it faxed directly from your medical office to Cannalogue at 1-833-295-5133 or mail it to P.O. Box 94 Stn Don Mills, North York, ON, M3C 2R6.

Healthcare Practitioner Information *(please complete all fields)*

Given Name: _____ Surname: _____ College No.: _____

Authorized Province/Territory: _____ Medical Licence: ◯ MD ◯ NP

Business Name and Address of Office/Clinic: _____

City: _____ Province/Territory: _____ Postal Code: _____

Office Phone: _____ Fax: _____ Email: _____

Patient Information *(please complete all fields)*

Given Name: _____ Surname: _____ Gender: ◯ Male ◯ Female ◯ Other

Date of Birth: _____ *(YYYY/MM/DD)* Home Phone: _____ Mobile Phone: _____

Health Card Number: _____ Residential Address: _____

City: _____ Province/Territory: _____ Postal Code: _____

Email: _____ Preferred Method of Contact: ◯ By Phone ◯ By Email

Diagnosis and Prescription

Consultation Address: ◯ **Same as Business Address** ◯ **Online** ◯ **Other** *(please specify)* _____

Medical Diagnosis: _____ Authorized Daily Quantity: _____ *grams*

Period of Use *(must not exceed 365 days)*: _____ *days* Recommended Products *(if any)*: _____

Restrictions *(if any)*: _____

Authorization of Healthcare Practitioner

I acknowledge that the information in this document is correct and complete, and that I have consulted with the patient or the patient's Responsible Adult.

☐ ***By providing my initials in the box to the left, I acknowledge that the faxed medical document sent to Cannalogue is the original and that I have retained this completed form as a copy for my medical records.***

Initial here

_____ _____

Healthcare Practitioner Signature **Date**