SOLACE HEALTH

MEDICAL DOCUMENT

VERSION 1.0

Patient Info

First Name: _____ Last Name: _____

Date of Birth (dd/mm/yy): _____ Contact: *Phone or Email* _____

Practitioner Info

First Name: _____ Last Name: _____ Profession: ☐ MD ☐ NP

License Number: _____ Province(s) Authorized to Practice in: _____

Phone Number: _____ Fax Number: _____

Business Address: _____

Consultation Location: *If different than business address.* _____

Authorization Details

Number of Grams per day: _____ Duration: *max 1 year* _____ ☐ Days ☐ Weeks ☐ Months ☐ 1 Year

Additional Info: ☐ Naive Patient ☐ Experienced Patient

Optional Diagnosis: _____

I hereby certify that the information in this document is correct and complete.

Signature of Practitioner: _____ Date (dd/mm/yy): _____

Initial here to confirm the original medical document has been sent via secure fax and that a copy has been kept on file at the clinic.

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