

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

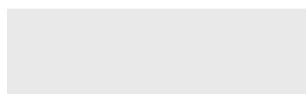
Number of Grams per _____ Duration: *max 1 year* _____ Days Weeks Months 1 Year

day: 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.

