SOLACE HEALTH

Online Marketplace for Licensed Producer TerrAscend Canada Inc.

MEDICAL DOCUMENT

VERSION 1.0

Patient Info

First Name: _____ Last Name: _____

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

Practitioner Info

Profession: MD ☐ NP ☐

First Name: _____ Last Name: _____

License # _____ Province(s) Authorized to Practice In: _____

Telephone: _____ Fax: _____

Business Address: _____ Suite No.: _____

City: _____ Province: _____ Postal Code: _____

Consultation Location: If different than business address _____

Authorization Details

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

Max amount of THC% or mg/mL (optional)

Is the max THC Limit

_____ Suggested ☐ Mandatory ☐

Patient can use - Check all that apply: (optional)

Is This?

Oils ☐ Dried ☐ Suggested ☐ Mandatory ☐

Additional Info (optional) Naive Patient ☐ Experienced Patient ☐

Diagnosis: _____

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

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

Initial Here:

I, the health care practitioner, acknowledge that the faxed medical document is now the original medical document and that I have retained a copy of this document for my records only.

T / 1-844-976-5223 F / 1-844-576-5223 E / INFO@SOLACEHEALTH.COM PO Box 43125 Mississauga ON, L5B 4A7