












Medical Document

To be completed by a prescriber for medical cannabis authorization

Patient information

















Fields marked with  are required. Information must match details on Patient Registration Form.

				
First name	Last name	Date of birth (mm/dd/yyyy)	Gender	
				
Primary phone number	Email address			
				
Diagnosis or condition (optional except for patients seeking coverage through Veterans Affairs)	Daily quantity (grams/day)	Period of use <i>Please note, period of use (in months) may not exceed 12</i>		



Optional information for product selection


- The Shoppers cannabis care advisor or pharmacist will support the patient with selecting their own product
- I have specific recommendations (e.g., producer, THC:CBD ratio, format, etc.) (please list)

Healthcare professional information

			
First name	Last name	Profession	Licence number
			
Authorized province of practice	Clinic name		
			
Clinic address	City	Province	
			
Postal code	Telephone	Fax	Email
Method of consultation	Location of consultation <input type="checkbox"/> Same as above		
<input type="checkbox"/> In person			
<input type="checkbox"/> Telemedicine	Address	City	Province Postal code

I consent to receive medical cannabis products at my business address on behalf of this patient. Initial: _____

I attest to the information in this medical document being correct and complete.	
	
Signature	Date (mm/dd/yyyy)

If faxing directly to Medical Cannabis by Shoppers Drug Mart Inc., I 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.	
	Initials

For healthcare professionals: Please fax this completed document to 1-866-220-2627 For patients: Please drop off this completed original document at your local Shoppers Drug Mart OR mail this original document to Medical Cannabis by Shoppers, 6941 Kennedy Road, Unit 100, Mississauga, ON L5T 2R6