AYURCANN

MEDICAL DOCUMENT

To be completed by your health care provider

PATIENT INFORMATION		
FIRST NAME	LAST NAME	DATE OF BIRTH (MMM/DD/YYYY)
TELEPHONE	EMAIL	GENDER ☐M ☐F ☐X

PRACTITIONER INFORMATION		
PROFESSION		MEDICAL LICENSE #
FIRST NAME	LAST NAME	BUSINESS NAME
TELEPHONE	FAX	EMAIL
PROVINCES LICENSED IN ☐ AB ☐ BC ☐ MB ☐ NB ☐ NL ☐ NS ☐ NT ☐ NU ☐ ON ☐ PE ☐ QC ☐ SK ☐ YT		
BUSINESS ADDRESS		
CITY	PROVINCE	POSTAL CODE

CONSULTATION ADDRESS IF DIFFERENT THAN ABOVE		
BUSINESS ADDRESS		
CITY	PROVINCE	POSTAL CODE
TELEPHONE	EMAIL	FAX

PERSCRIPTION	
MEDICAL DIAGNOSIS (*MUST BE COMPLETED FOR VETERANS*)	
NUMBER OF GRAMS PER DAY	DURATION (*MINIMUM 30 DAYS TO A MAXIMUM OF 12 MONTHS*) _____DAYS _____ MONTHS
HEALTH CARE PRACTITIONER'S SIGNATURE	DATE (*MMM/DD/YYYY*)

BY SIGNING THIS DOCUMENT, I ATTEST THAT THE INFORMATION CONTAINED IN THIS DOCUMENT IS CORRECT AND COMPLETE

☐ CHECK BOX IF YOU ARE SUBMITTING THIS MEDICAL DOCUMENT TO AYURCANN VIA FAX: I HAVE CHOSEN TO SUBMIT THE MEDICAL DOCUMENT TO AYURCANN VIA AYURCANN'S SECURE FAX ePORTAL. I ACKNOWLEDGE THAT THE FAXED MEDICAL DOCUMENT IS NOW THE ORIGIANL MEDICAL DOCUMENT AND THAT I HAVE RETAINED A COPY OF THIS DOCUMENT FOR MY RECORDS ONLY.