

Questions?

We're here to help!
Email: AskUs@MedReleaf.com
Phone: 1.855.4.RELEAF (473.5323)
Secure eFax: 1-866-264-4139

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MEDRELEAF
THE MEDICAL GRADE STANDARD™

MEDICAL DOCUMENT - To be completed by a Health Care Practitioner

SECTION 1 - PATIENT INFORMATION

Patient's name
Given First Name(s) Surname (Last Name) DOB (DD/MM/YY)

Patient's email

SECTION 2 - HEALTH CARE PRACTITIONER

Name
Title Given First Name(s) Surname (Last Name)

Profession License #
(CPSO, CPSBC, CMQ)

Health care practitioner's business address

or

Full business address of the location at which the patient consulted the health care practitioner (if different)

NOTE: STAMP OR STICKER IS ACCEPTABLE HERE

Phone # Ext Fax #

Email Province(s) Authorized to Practice in

SECTION 3 - ORDER FOR MEDICAL MARIHUANA (CANNABIS)

Quantity | attest that the information contained herein is correct & complete
grams/day Duration - # of Days Name of Health Care Practitioner

Diagnosis
(Optional)

Date Signed
(DD/MM/YY)

Healthcare Practitioner's Signature

PLEASE INITIAL HERE IF SUBMITTING THIS DOCUMENT TO MEDRELEAF BY FAX
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I have chosen to submit the original Medical Document to MedReleaf via MedReleaf's secure fax. 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. Secure eFax: 1-866-264-4139

Send completed documents to
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