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

www.MedReleaf.com

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: ______ grams/day | 365 day maximum ______ Duration - # of Days

I ______ Name of Health Care Practitioner attest that the information contained herein is correct & complete

Diagnosis: ______

Date Signed: ______ (DD/MM/YY)

PLEASE INITIAL HERE IF SUBMITTING THIS DOCUMENT TO MEDRELEAF BY FAX
Secure eFax: 1-866-264-4139

Healthcare Practitioner's Signature: ______

Send completed documents to:
MedReleaf
P.O. Box 3040
Markham Industrial Park
Markham ON, Canada
L3R 6G4

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

My signature acknowledges that: (i) I am the prescribing healthcare practitioner for this patient; (ii) this constitutes an original Order for Medical Cannabis for this patient; and (iii) subject to the patient's consent, I agree to be contacted by MedReleaf Corp. with regard to this patient.