# MEDICAL DOCUMENT

Licensed under the Cannabis Act by HydRx Farms Ltd.

This form is to be completed by a Health Care Provider licensed to authorize medical cannabis.

Instructions for the Health Care Provider:

There are two ways to send us this document:

1. Secure Fax - We can accept this document by fax only if it is faxed directly from your office with your acknowledgement that the faxed Medical Document is the original Medical Document. See section 5 on the next page.

2. Original Paper Copy - The original version of this Medical Document, completed and signed by the Health Care Provider, can be mailed to us.

Instructions for the Patient:

The patient must submit a separate Registration Form to accompany this document.

This can be done online at HydRx.ca. Alternatively, the patient may submit a paper copy of the Registration Form. This can be downloaded from HydRx.ca/registration.

Medical Education:

For more information, visit our website where you will find information for Health Care Providers.

For more information c/o HydRx Farms Ltd.
209 Dundas St.E., PO Box 31
Whitby, ON, Canada
L1N 5R7

1-844-493-7922
customercare@hydrx.ca

Secure Fax Line
(866) 775-7552

# MEDICAL DOCUMENT

## 1. Health Care Provider

First name | Last name | Title

Profession | Business Address | Unit Number

City | Province | Postal Code | Phone

Fax | Email

Medical License Number *(indicate province if different than above)* | Location of consultation *(if different from Health Care Provider address above)*

## 2. Patient Information

First name | Last name | Date of birth

Phone | Email

## 3. Dosing Information

**Important for Health Care Providers: The Cannabis Act mandates that authorization be in grams per day, even if the patient will be taking oils or softgel capsules.**

According to Health Canada, the average amount of cannabis consumed by patients for medical purposes is 1-3 grams per day. There is, however, no limit to the daily allowable amount that can be authorized.

Quantity (required): _____ g/day Period of use (required): _____ months (12 month maximum)

THC maximum (optional): ◯ _____ mg/mL cannabis oil ◯ _____ mg/capsule

Diagnosis (required only if document will be submitted to Veterans Affairs Canada) _____

## 4. Certification by Health Care Provider

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

Signature | Full name | Date

## 5. Initial Here if Submitting the Medical Document by Secure Fax

I have chosen to submit the original Medical Document via 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.

Initial here _____

## 6. Further Information Available to Health Care Providers

◯ Please follow up with my office to schedule a brief information session on medical cannabis

◯ Please deliver materials for my clinic

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