TANTUSHEALTHCO

MEDICAL REGISTRATION

Patient Information

All fields are required unless otherwise noted. This form must be completed by the Health Care Pracitioner. If a caregiver is responsible for the patient, Caregivers must also complete the Caregiver Information form.

Caregiver Required? Yes* ☐ No ☐ *If yes, complete the Patient & Caregiver Information form to send with this document.

Patient Name First Name | Last Name

Email | **Telephone**

Date of Birth Year / Month / Day | **Referred by:**

Address

Address

City | Province | Postal Code

Form Valid Until Year / Month / Day (max. 12 months) | **Period of Use** (max. 12 months) Months(s)

Purpose of Use Primary Condition (Optional) | **Daily Usage** (max. 150 g/month Dry Flower Equivalent) g/day

Type of Product ☐ Dried Only ☐ Extract Only

If neither option is selected, the patient will be able to order any combination of extracts or dried cannabis products

Potency Guidance ☐ % THC max (for Flower) ☐ mg/ml THC max (for extracts)

Health Care Practitioner Information

Title / Name Title | Given Name | Surname

Profession

Province of Practice Province in which Practitioner is Authorized to practice | **License No.** License number issued by Provincial Body (not MSP)

Organization Name

Address

Address

City | Province | Postal Code

Contact Information Email Address | Phone (required) and Fax (optional)

Practitioner Signature Practitioner hereby attests that the information in this document is correct and complete | Year / Month / Day

Practitioner Initials ☐ Practitioner hereby acknowledges that the faxed Medical Document constitutes the original Medical Document and that he/she has retained a copy of the Medical Document for his/her records. To further protect Patient Privacy, the Practitioner further attests that the Medical Document will not be faxed to or provided to any other party.

(only required when faxing document)

www.tantushealthco.com
clientcare@tantushealthco.com
1 866 904 0806 | fax: 1 (236) 455 6400

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30621 Madison PO, Burnaby BC V5C 6J5