CENTRE DE COMPASSION
GREEN FOREST

Phone: 450-477-0503

Fax: 450-477-6088

Email: info@laforetverte.ca

Address: 1430 Montée Major, Terrebonne suite 100, J7M 2G3

For validation this form must be filled in by an MD, ND, or DR. TCM, and faxed from the practitioner office to Centre de compassion Forêt Verte.

Patient's name: _____

Date of birth: _____

I am willing to confirm that Mr./Mrs./Ms _____
at phone number (_____) _____ has been diagnosed with _____

_____

and is presenting symptoms of

_____

☐ I recommend cannabis to help my patient with her/his symptoms.

☐ This patient has reported that her/his symptoms are helped by cannabis and therefore, on the basis of my knowledge, she/he should have access o it.

☐ This patient has reported that her/his symptoms are helped by cannabis.

☐ ❑ I do not recommend the use of cannabis for the reasons stated below:

Medical: Please specify

legal: Please explain

Other: Please explain

This patient is in a critical stage of their illness or treatment and requires immediate attention.

PRACTITIONER'S SIGNATURE: _____ _____

PRINTED NAME: _____

DATE SIGNED: _____

PRACTITIONER'S PHONE:_____

_____

PRACTITIONER'S ADDRESS: _____

PRACTITIONER'S STAMP/LICENSE