# Breathing Green Solutions Medical Document

IMPORTANT:

This form must be completed by a physician who is licensed in Canada.

If another document is used in place of this one, it must contain all of the information on the following page.

If you wish to have additional information sent, contact our Client Services Team at 1.833.259.3200 or visit our website at www.breathinggreen.com

**INSTRUCTIONS TO HEALTHCARE PRACTITIONER:**
We appreciate you taking the time to consider whether medical cannabis meets the needs of your patient. To preserve the integrity of the information provided, we ask that no stamps be used to fill out this Medical Document.

**Two ways to send:**
**SECURE FAX: 902.700.5214**
**MAIL: ATTN: Breathing Green Client Services Centre**
**15693 Highway 4 Wentworth, NS B0M 1Z0**

**MAIL:** If sending via mail, ensure the Medical Document is completed and signed by a Healthcare Practitioner and is the **original** copy.

**FAX:** If sending via secure fax, ensure it is faxed directly from your Healthcare Practitioner's office and initialed at the bottom declaring it the original.

If you need any assistance, our Client Services Team is always happy to help.

The Breathing Green Team.

If you have any questions please contact our Client Services Team or toll-free 1-833-259-3200

This form is to be completed by your Healthcare Practitioner

## CLIENT INFORMATION

**Patient Name**

Given Name | (Middle Name) | Surname

**Date of Birth**

YYYY/MM/DD

**Gender**

☐ Male ☐ Female ☐ Other

**Contact Information**

Phone # | Email

## HEALTHCARE PRACTITIONER INFORMATION – PLEASE DO NOT STAMP INFORMATION

**Practitioner**

Title | Given Name | Surname

**General Information**

Profession | License # (CPSO, CPSBC, CMQ) | Province(s) authorized to practice in

**Contact Information**

Phone # | Fax # | Email

**Business Information**

Name & Address | Unit # (if applicable)

City | Province | Postal code

**Consultation Business Information (if different from business information)**

Name & Address | Unit # (if applicable)

City | Province | Postal code

Phone # | Fax # | Email

## PRESCRIPTION

**Note: The period of use cannot exceed one year**

Grams/Day | THC Limit (%) | Day(s) | Week(s) | Month(s) | Primary Condition

**By signing this document, the Healthcare Practitioner is attesting that the information contained in this document is correct and complete.**

**Signature of Healthcare Practitioner**

**Date of Signature (YYYY/MM/DD)**

If the patient chooses to produce cannabis for their own medical purposes or you are not submitting this document via secure fax do not initial the box below. If your patient chooses to access cannabis for medical purposes via a licensed producer, this medical document can be submitted from the Healthcare Practitioner's office to the licensed producer by secure fax. If you choose to submit the medical document by secure fax, initial the statement below to acknowledge agreement.

I, the Healthcare Practitioner, 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.

**HEALTHCARE PRACTITIONERS INITIAL(S)** ☐