P.O. Box 696 Cobourg, ON, K9A 4R5
Toll-free number: 1-833-290-8878
Secure Fax: 1-833-818-9025
Email: info@fvpharma.com
www.fvpharma.com

MEDICAL DOCUMENT

To be completed by your Health Care Practitioner

PATIENT INFORMATION

Given First Name

Surname

☐ Male ☐ Female ____ / ____ / ____
D.O.B. (DD/MM/YYYY)

☐ Other

Primary Phone Number | Secondary Phone Number

HEALTH CARE PRACTITIONER INFORMATION

Title | Given Name

Surname | Profession

License # (CPSO, CPSBC, CMQ) | Email

Phone | Fax

Business Address

Unit No. (if applicable) | City

Province | Postal Code

Province(s) Authorized to Practice in (check all that apply)

☐ AB ☐ BC ☐ MB ☐ NB ☐ NL ☐ NT ☐ NS

☐ NU ☐ ON ☐ PEI ☐ QB ☐ SK ☐ YT

CONSULTATION ADDRESS

☐ Same as Business Address

Consultation Address

Unit No. (if applicable) | City

Province | Postal Code

PRESCRIPTION

Grams/Day | Duration in Days (Max. 365 days)

Max. THC (not required) | Medical Condition

Healthcare Practitioner Notes

☐ Mandatory if checked

SIGNATURE

HEALTH CARE PRACTITIONER: Initial if you are submitting the Medical Document to FV Pharma by Fax. I, the patient's Health Care Practitioner, 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 the document in my possession reverts to a copy retained for record keeping purposes only.

HEALTH CARE PRACTITIONER: Sign if you agree that all the information on the Medical Document is true and correct. I, the patient's Health Care Practitioner, certify that the information on this Medical Document is correct and complete.

Signature of Health Care Practitioner | Date (DD/MM/YYYY)

Your Medical Document may be submitted to us by mailing the original version or by faxing a copy of the original. It may be sent to the address or fax number on the top right corner of this document depending on your preferred method. If you choose to fax this document it must be faxed by your health care practitioner from their business address.

Please fax a copy of the original document or mail the original Medical Document.

Please fax the completed Medical Document to:
Secure fax number: 1-833-818-9025

Mail original Medical Document to:
Customer Care - P.O. Box 696, Cobourg, ON, K9A 4R5

Please contact our Customer Care Team at 1-833-290-8878 if you have questions regarding this form.