AURORA®

MEDICAL DOCUMENT

To be completed by your Health Care Practitioner

All fields are mandatory unless specified with an * and relative notes. Clarification to those fields may be provided.

Aurora Cannabis Enterprises Inc.
Email: clientcare@auroramj.com
P.O. Box 209
Cremona, AB. T0M 0R0
Phone: 1-844-928-7672
Fax: 403-637-3121

Patient Information

Please contact our client care team at 1-844-928-7672 if you have any questions regarding this form.

Patient Name
Given Name | Surname

Date of Birth
Year | Month | Day

Gender ☐ Male ☐ Female

Contact Info (Complete one or more)
Phone | Email | Fax or secondary phone

Health Care Practitioner Information

Practitioner Title and Name
Title | Given Name | Surname

General Info
Profession | License # (CPSO, CPSBC, CMQ) | Province(s) Authorized to Practice in

Contact Info (Complete one or more)
Phone | Email | Fax

Business Address
Business Address | Unit Number (If applicable)
City | Province | Postal Code

***Consultation Address**

☐ **Same as above**

Consultation Address | Unit Number (If applicable)
City | Province | Postal Code

Prescription

Quantity/Diagnosis
Grams/Day

◯Days ◯Weeks ◯Months
Period of Use (Maximum of 365 days)

Primary Condition (required only if document will be submitted to Veterans Affairs)

Signature

I attest that the information in this document is correct and complete

Signature of Health Care Practitioner

Date
Year | Month | Day

Submission and Shipping (If Applicable)

*Required if applicable. 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 upon your preferred method. If you choose to fax this document it must be faxed by your health care practitioner from their business address.

☐ **HEALTH CARE PRACTITIONER INITIAL IF YOU ARE SUBMITTING THE MEDICAL DOCUMENT TO AURORA BY FAX.**
I, the patient's Health Care Practitioner, have chosen to submit the original *Medical Document* via Aurora's secure fax ePortal. 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 INITIAL IF YOU WILL BE RECIEVING THE PATIENT'S MEDICAL MARIJUANA TO YOUR BUSINESS ADDRESS.**
I, the patient's Health Care Practitioner, consent to recieve medical marijuana on behalf of the patient at the business address on this *Medical Document.*
Note: If at anytime you cease to consent to recieve medical marijuana on behalf of the patient, you must send a written notice to that effect to both the patient and the licensed producer.