PHONE: 1-844-928-7672 | EMAIL: CLIENTCARE@AURORAMJ.COM | FAX: 403-637-3121

AURORA®

MEDICAL DOCUMENT

TO BE COMPLETED BY YOUR HEALTH CARE PRACTITIONER

ALL FIELDS ARE MANDATORY UNLESS SPECIFIED WITH AN ◆ AND RELATIVE NOTES. USE A PEN AND PRINT AS CLEARLY AS POSSIBLE.

1. PATIENT INFORMATION

PATIENT NAME

FIRST NAME

LAST NAME

DATE OF BIRTH

YEAR MONTH DAY

CONTACT INFO

EMAIL

PHONE

2. HEALTH CARE PRACTITIONER INFORMATION

PRACTITIONER TITLE AND NAME

TITLE

FIRST NAME

LAST NAME

GENERAL INFO

PROFESSION

LICENCE # (CPSO, CPSBC, CMQ)

PROVINCE(S) LICENSED TO PRACTISE IN

CONTACT INFO

EMAIL

PHONE

FAX

BUSINESS ADDRESS

UNIT NUMBER

ADDRESS LINE 1

ADDRESS LINE 2

CITY, TOWN OR VILLAGE

PROVINCE OR TERRITORY

POSTAL CODE

CONSULTATION ADDRESS

☐ IF DIFFERENT THAN ABOVE

UNIT NUMBER

ADDRESS LINE 1

ADDRESS LINE 2

CITY, TOWN OR VILLAGE

PROVINCE OR TERRITORY

POSTAL CODE

3. PRESCRIPTION

QUANTITY/DIAGNOSIS

GRAMS/DAY

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.

X

SIGNATURE OF HEALTH CARE PRACTITIONER

YEAR MONTH DAY

4.SUBMISSION AND SHIPPING ◆ 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 in the header 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.

☐ **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 RECEIVING THE PATIENT'S MEDICAL CANNABIS TO YOUR BUSINESS ADDRESS**
I, the patient's health care practitioner, consent to receive medical cannabis on behalf of the patient at the business address on this medical document.
Note: If at any time you cease to consent to receive medical cannabis on behalf of the patient, you must send a written notice to that effect to both the patient and the licensed producer.