



Attn: Patient Care Team  
PO Box 50024  
205 Pleasant Street  
Dartmouth, NS B2Y 3R0

Tel: 902-932-8584  
 Secure Fax: 902-932-8584  
*Our main phone line receives secure faxes*  
 info@eastcann.ca | www.eastcann.ca

**SECTION 1: Patient Information**

First Name:

Date of Birth: (MM/DD/YY)

Last Name:

Email Address:

**SECTION 2: Health Care Practitioner**

Title:

First Name:

Last Name:

Profession:

License #:

License Province:

Health care practitioner's business address

**OR**

Full business address of the location at which the patient consulted with the Health Care Practitioner (if different).

  
  
  
  
*NOTE: STAMP OR STICKER IS ACCEPTABLE*

Phone #:

Extension #:

Fax #:

Email address:

**SECTION 3: ORDER FOR MEDICAL CANNABIS**

Quantity (grams per day):

Duration - # of Days (365 Day Max)

Name of Health Care Practitioner:

Diagnosis:

*Attest that the information contained herein is correct & complete*

Additional information: (strain recommendations, THC restrictions):

Mandatory if checked:

Specify type of Cannabis: Oil  Dried  Both

**Healthcare Practitioner's Signature:**

Date Signed (DD/MM/YY):

**PLEASE INITIAL HERE IF SUBMITTING DOCUMENT BY FAX**

I have chosen to submit the original documents to EASTCANN via fax. I 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.

*\*EASTCANN is a business name of the license holder "Prime Pot Inc".*