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
medical@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:

Attest that the information contained herein is correct & complete

Diagnosis:

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".*