PHONE: 1-877-9AURORA | EMAIL: REGISTRATION@AURORAMEDICAL.COM | FAX: 403-637-3121

AURORA™

MEDICAL DOCUMENT

TO BE COMPLETED BY YOUR HEALTHCARE PRACTITIONER

SECTION 1 – PATIENT INFORMATION

FIRST NAME

LAST NAME

DATE OF BIRTH (YEAR/MONTH/DAY) Y Y Y Y M M D D

EMAIL

MOBILE PHONE NUMBER

STREET ADDRESS

UNIT / APARTMENT NUMBER

CITY, TOWN OR VILLAGE

PROVINCE OR TERRITORY

POSTAL CODE

SECTION 2 - PRACTITIONER INFORMATION

TITLE

FIRST NAME

LAST NAME

PROFESSION

LICENCE # (CPSO, CPSBC, CMQ, ETC)

PROVINCE(S) LICENSED TO PRACTICE

EMAIL

MOBILE PHONE NUMBER

FAX

BUSINESS ADDRESS

STREET ADDRESS

UNIT / APARTMENT NUMBER

ADDRESS LINE 2

CITY, TOWN OR VILLAGE

PROVINCE OR TERRITORY

POSTAL CODE

CONSULTATION ADDRESS

☐ IF DIFFERENT FROM BUSINESS ADDRESS LISTED ABOVE

STREET ADDRESS

UNIT NUMBER

ADDRESS LINE 2

CITY, TOWN OR VILLAGE

PROVINCE OR TERRITORY

POSTAL CODE

SECTION 3 - PRESCRIPTION INFORMATION

2.1 grams per day is the average authorized amount per patient. *Health Canada Market Data,* 2 Dec 2019.

QUANTITY **DURATION** **DIAGNOSIS**

GRAMS/DAY

PERIOD OF USE IN DAYS (MAXIMUM OF 365 DAYS)

PRIMARY CONDITION (REQUIRED IF DOCUMENT WILL BE SUBMITTED TO VETERANS AFFAIRS)

I ATTEST THAT THE INFORMATION IN THIS DOCUMENT IS CORRECT AND COMPLETE.

X

SIGNATURE OF HEALTHCARE PRACTITIONER

YEAR Y Y Y Y

MONTH M M

DAY D D

NOTES:

Your medical document may be submitted to us by mailing the original version or by sending a copy of the original electronically. It may be sent to the address, email or fax number in the header of this document depending on your preferred method. If you choose to submit this document electronically it must be emailed or faxed by your healthcare practitioner from their business address.

INITIALS

HEALTHCARE PRACTITIONER INITIAL IF YOU ARE SUBMITTING THE MEDICAL DOCUMENT TO AURORA® ELECTRONICALLY

I, the patient's healthcare practitioner, have chosen to submit the original medical document securely to Aurora®, electronically. I acknowledge that the electronic version of the medical document is now the original medical document and the document in my possession reverts to a copy retained for record keeping purposes only.

INITIALS

HEALTHCARE PRACTITIONER INITIAL IF YOU WILL BE RECEIVING THE PATIENT'S MEDICAL CANNABIS TO YOUR BUSINESS ADDRESS

I, the patient's healthcare 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.