TIDAL HEALTH SOLUTIONS LTD.
Mail to: PO Box 10, St. Stephen,
NB, E3L 2W9 Canada
1-833-275-1420
Fax: 1-506-465-9683
customerservice@tidalhealth.ca

MEDICAL DOCUMENT

To be completed by a Health Care Practitioner.
All fields required under regulation unless otherwise noted.

PATIENT INFORMATION

Information must match information on patient registration

CAREGIVER REQUIRED? ☐ Yes* ☐ No *If yes, please complete in full the Caregiver form attached to this medical document.

PATIENT NAME
First Name
Last Name

CONTACT
Telephone
Fax
Email

DATE OF BIRTH
Year Month Day

PERIOD OF USE
Month(s)
Note: Duration Cannot Exceed One Year

DAILY PRESCRIPTION
Grams/Day

☐ Dried Only ☐ Extract Only
If neither option is selected, the patient will be able to order any combination of extracts or dried cannabis products.

Primary Condition

HEALTH CARE PRACTITIONER INFORMATION

Please print clearly in full (no abbreviations).

TITLE / NAME
Title Given Name Surname

PROFESSION

BUSINESS / CLINIC NAME

BUSINESS ADDRESS
Address
City Province Postal Code

CONSULTATION ADDRESS
Address of Consultation Location with Patient (If Different Than Above)
City Province Postal Code

PHONE / FAX / EMAIL
Telephone (Required) Fax (If Applicable) Email (If Applicable)

LICENCE NUMBER
Licence number issued by Provincial College Note: Do not enter billing number (e.g. MSP no.)

PROVINCE OF PRACTICE
Province in which Practitioner is Authorized to Practice

SIGNATURE
By signing, the Practitioner attests that the information in this document is correct and complete
Year Month Day

PRACTITIONER INITIALS
(Use only when faxing document)

By initialling, Practitioner acknowledges that the Medical Document faxed to Tidal constitutes the original Medical Document and that he/she has retained a copy of the Medical Document for his/her records. Practitioner also attests that the Medical Document will not be faxed or provided to any party other than TIdal.