Medical Marijuana Consulting
124 Wellington Street E
Aurora, ON
L4G 1J1

P: 1-844-312-5143, ext. 110
F: 1-844-633-6422
E: caf@medmc.ca

Patient Information

First Name: ____________ Middle Name: ____________
Last Name: ______________________________________
Date of Birth (YYYY/MM/DD): ______/______/______
Gender: ☐ Male ☐ Female ☐ Other
Address: ____
City: ____
Province: _____________ Postal Code: ______________
Phone/Extension: _________________________________
Email: ____
Health Card #: ___________________________________

How would you classify yourself? ☐ First Responder ☐ RCMP ☐ Still Serving ☐ Veteran **K#:** ____________

For veterans, do you have an awarded condition? ☐ Yes ☐ No If yes, please list here: ____________________

Physician Assessment

I'm seeking cannabis to treat: ____
____

This symptom prevents me from being able to: ____________________________
____

Known allergies to medications and reactions: ____________________________
____

Products and Services		Please select all that apply.
Cannabis Products	**Compounded Pain Creams**	**Services**
☐ Dry Cannabis	☐ Joint and Inflammation	☐ Coverage
☐ Milled Cannabis	☐ Neuropathic Pain	☐ Veteran Benefit Support
☐ CBD Oil	☐ Migraines	☐ Cannabis ID Card
☐ THC Oil	☐ Muscle Relaxant	☐ Licensed Producer Discount for Still Serving Members and First Responders
☐ 1:1 Oil	☐ Muscle & Soft Tissue Pain	
☐ Capsules		
☐ Sublingual Sprays		

Emergency Contact

First Name: ______________ Last Name: ____________________________ Relationship: ______________
Phone: ________________________ Email: ____
I give MMC consent to speak to this person about my cannabis treatment. ☐ Yes ☐ No

Physician Information

Physician's Name: ____________________________ Phone: ________________ Fax: ________________

CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION

I, ___________________________ (first and last name), acknowledge, agree, and/or grant permission to Medical Marijuana Consulting to access my prescription, medical documents, and/or personal health information, which may consist of dosing information of topical compound creams and/or cannabis used for medical purposes, which is used as verification of the healthcare practitioner's order required by a physician, pharmacy, or licensed producer.

I grant permission to the pharmacy or licensed producer of my choosing, specified on the prescription or medical documents, to share my application and related materials with your insurance provider including recommended dose information for the purpose of facilitating direct billing for insurance purposes. I also grant the pharmacy or licensed producer permission to disclose personal and sales-related information to Medical Marijuana Consulting for tracking and information purposes.

I acknowledge the indications, safety, and understand that the risks of dried cannabis use has not been adequately studied and that the appropriate dose is unclear and may vary person to person. I acknowledge that any medical cannabis product obtained from a licensed producer is done so at my own risk and I release Medical Marijuana Consulting from all and any actions, claims, complaints, and demands for damages, loss, or injury whatsoever, arising directly or indirectly as a consequence of the use of medical cannabis products.

I understand that the purpose of disclosing this personal health information to the company noted above is in order to provide products or services offered by Medical Marijuana Consulting. I understand that I can refuse to sign this consent form. I have not been coerced to sign this consent form and am signing this form under my own free will.

By my signature below, I certify that the information on this form and in connection with my registration, is true and accurate. I acknowledge that I am responsible for the information that I provided and any costs associated with providing false information.

Signature: _______________________________________ Date (YYYY/MM/DD): _______/_______/_______

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