Marijuana for Medical Purposes
Patient Medical Document

This document outlines the information a Yukon physician must collect from a patient seeking marijuana for medical purposes. **(Please refer to Marijuana for Medical Purposes Standard of Practice)**

PATIENT INFORMATION

Surname: _____ Given Name(s): _____

Date of Birth (DD/MM/YYYY): _____ Yukon Health Care #: _____

Daily quantity of dried marijuana to be used by the patient: _____ g/day

Period of use: _____ day(s) _____ week(s) _____ month(s)

Note: the period of use cannot exceed one year

General Comments: _____

_____

_____

PHYSICIAN INFORMATION

Surname: _____ Given Name(s): _____

Physician's business address: _____

_____

Address at which the physician treated the patient (*if different from above*): _____

_____

Phone number: _____ Fax number: _____

Email address: _____

By signing this document, I attest that the information contained in this document is correct and complete.

Physician's Signature: _____

Date Signed (DD/MM/YYYY) _____

****This document must be provided to the Yukon Medical Council upon request.****