

PATIENT INFORMATION

Mrs. Miss Ms. Mr.

Applicant's full name: _____ first | _____ middle | _____ last

Date of Birth: _____ day | _____ month | _____ year Telephone: () _____

Address: _____ Apartment #: _____

City: _____ Province: _____ Postal Code: _____

E-mail: _____ Referred By: _____

PATIENT DIAGNOSIS INFORMATION

Category 1

	SEVERE PAIN	MUSCLE SPASM	CACHEXIA	ANOREXIA	WEIGHT LOSS	NAUSEA	SEIZURES
MULTIPLE SCLEROSIS							
SPINAL CORD INJURY							
SPINAL CORD DISEASE							
CANCER							
HIV INFECTION							
SEVERE ARTHRITIS							
EPILEPSY							

Category 2

Patient Has Been Diagnosed With: _____

And/Or Suffers from the Following Symptoms: _____

Can you provide documentation from a relevant specialist confirming this diagnosis YES NO

PHYSICIAN INFORMATION

Medical Practitioner's full name: _____ first | _____ middle | _____ last

Provincial Medical licence #: _____ Medical Specialization (if applicable): _____

Business Address: _____ Suite #: _____

City: _____ Province: _____ Postal Code: _____

Telephone: () _____ E-mail: _____

Medical Practitioner's Signature: _____ Date: _____