Sora Care

A virtual clinic dedicated to medical cannabis across Canada.

T: (844) 223-8886
F: (844) 332-7716
E: info@sora.care
W: sora.care

Medical Document

Patient Information

First Name: _____ **Last Name:** _____

Date of Birth: _____ **Phone 1 / Cell:** _____

Pronouns: ☐ He ☐ She ☐ They ☐ Other: _____ **Phone 2:** _____

Insurance Provider: _____ **Email:** _____

☐ *Please confirm if patient is in need of shared care & education support from Sora Care*

Prescription

Daily quantity of dried cannabis (Grams): _____ **Period of use** (Months): _____

I choose to send this Medical Document to _____ via secure fax in accordance with the provincial medical college guidelines for Electronic Signatures.

I acknowledge that the received medical document is now the original document and I have retained acopy for office records only.

This prescription may only be filled by the above Licensed Seller authorized by Health Canada in accordance with the Cannabis Act.

Specific Instructions

Unless otherwise indicated above, this patient is authorized for all cannabis products in accordance with this prescription. Please refer to patient's treatment plan for all specific product recommendations.

Healthcare Practitioner Declaration

I attest that the information contained herein is correct and complete.

Name: _____

License #: _____ **Province:** _____

Signature: _____

Date: _____

The consultation took place at the business address:

Address: _____

City: _____ Province: _____

Postal Code: _____

Phone: _____ Fax: _____

STAMP

Email: _____

☐ **Please confirm if interested to learn about cannabis and medical cannabis training opportunities (Please add email above)**