

Non-Standard Letter of Diagnosis

My patient, _____ D.O.B _____

has been diagnosed with: _____

symptoms include: _____

*I understand that my office will be contacted by telephone to verify this information. I have discussed the use of cannabis with my patient and will continue to monitor their condition.

To be completed by
M.D. __ R.N. (E.C) __ N.P. Doctor __ Chiropractor __

Practitioner's Name: _____ Reg.# _____

Practitioner's Signature: _____

Medical Practitioner's Address:

Phone # _____

Date signed: _____ / _____ / _____
(Month) (Day) (Year)

Patient Contact Information: IMPORTANT

Address _____

Phone # _____ Email _____

Please keep a copy of this form at your doctor's office
CALM reserves the right to refuse any member on a case by case basis

Please complete and fax or send to:
P.O. Box 47023, RPO 425
Toronto, Ontario M5B 2P9
Telephone: 416-367-3459 Fax: 416-367-4679