KOLAB PROJECT

Kolab Care Team
1-833-565-2278
kolabcare@kolabproject.com
Monday-Friday
9:00 AM to 5:00 PM EST

MEDICAL DOCUMENT – TO BE COMPLETED BY HEALTH CARE PRACTITIONER

Please complete, sign and send back the **MEDICAL DOCUMENT** to Kolab Project either by original paper copy or secure fax.

1. Mail the original, completed and signed version of the Medical Document to 55 Bruce Crescent, Carleton Place, Ontario K7C 3T3 **OR**

2. Send this document by secure fax to 1-855-640-5005.

PATIENT INFORMATION

First Name _____ Last Name _____

Date of Birth _____ Gender ☐ Male ☐ Female ☐ Other

Primary Phone _____ Email Address _____

HEALTH CARE PRACTITIONER INFORMATION

Title/Profession _____ Institution Name _____

First Name _____ Last Name _____

Medical License Number _____ Province of Issue _____

Provinces Licensed In

☐ Alberta
☐ British Columbia
☐ Manitoba
☐ New Brunswick
☐ Newfoundland and Labrador
☐ Nova Scotia
☐ Northwest Territories
☐ Nunavut
☐ Ontario
☐ Prince Edward Island
☐ Quebec
☐ Saskatchewan
☐ Yukon

Business Address _____ Consultation Address _____

Telephone _____ Email _____

WRITTEN ORDER

Medical Diagnosis (Optional) _____

Grams per Day _____

Duration (Months) _____

Other Prescription Information _____

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

Health Care Practitioner's Signature _____

Date _____