**STARSEED**
Medicinal Inc.

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# Medical Documentation

A health care practitioner must complete the following medical document for a person who is under their professional treatment

## HEALTH CARE PRACTITIONER

**Last Name** **First Name**

**Profession** **Clinic No.**

**Medical License #** **Province Licensed To Practice**

**Address**

**City** **Province** **Postal Code**

**Telephone*** Required **Fax**

**Email*** Required **Preferred contact method** ◯ Phone ◯ Email ◯ Fax

## PATIENT'S INFORMATION

**Last Name** **First Name**

**Date of Birth** MMM / DD / YYYY **Telephone**

**Gender** ◯ Male ◯ Female ◯ X **Medical Diagnosis:** (optional)

## CONSULTATION ADDRESS (IF DIFFERENT FROM ABOVE)

Address of the location at which the patient consulted with the practitioner.

**Address**

**City** **Province** **Postal Code**

## MEDICAL REQUIREMENTS

The amount of dried cannabis or cannabis oil to be used by the patient must be expressed in terms of total grams of dried cannabis authorized daily.

grams/day for ◯ Days ◯ Weeks ◯ Months

The medical document is valid for the period of use specified. Must not exceed one year.

## TREATMENT PARAMETERS

Please select the product with the ***maximum THC level*** below.

**Dried Cannabis**

| √ | Product | Description | THC | CBD |
|---|---|---|---|---|
| ☐ | Green Star 1 | High CBD | < 2 % | ≥ 7 % |
| ☐ | Green Star 2 | 1 to 1 CBD/THC | ≥ 2 % to ≤ 12 % | ≥ 2 % to ≤ 12 % |
| ☐ | Green Star 3 | Moderate THC | ≥ 9 % to ≤ 16 % | < 2 % |
| ☐ | Green Star 4 | High THC | > 16 % to ≤ 28 % | < 2 % |

**Cannabis Oil**

| √ | Product | Description | THC | CBD |
|---|---|---|---|---|
| ☐ | Blue Star 1 | High CBD | ≤ 2.8 mg/mL | ≥ 17 mg/mL |
| ☐ | Blue Star 2 | 1 to 1 CBD/THC | ≥ 8 to ≤ 17 mg/mL | ≥ 8 to ≤ 17 mg/mL |
| ☐ | Blue Star 3 | High THC | > 17 to ≤ 28 mg/mL | ≤ 2 mg/mL |

**OR** Please enter a ***maximum THC (percent or mg/mL)*** below.

**Max THC** ◯ Oil ◯ Dried ◯ Both **Notes**

## AUTHORIZATION OF HEALTH CARE PRACTITIONER

I attest that the information in this document is correct and complete and that I have consulted with the Patient referenced above.

**Health Care Practitioner's Signature** **Date** MMM / DD / YYYY

☐ Check here if you are submitting the Medical Document to Starseed using Starseed's secure online physician portal or the secure electronic Sfax system to attest to the following:

The provincial professional licensing authority of the province(s) in which I am authorized to practice approve the use of electronic medical documents and I have chosen to submit the original Medical Document to Starseed via the secure online physician portal or secure electronic Sfax system. I acknowledge that, in the case of Sfax submission, that the faxed medical document is now the original Medical Document and that I have retained a copy of this document for my records only.

***If you are submitting by way of secure fax, please fax this completed document to 1-844-756-0470.***

We can only accept this document via the SFax system if it is sent directly from a medical office, and only with the acknowledgment by the prescribing physician that the faxed medical document is the original Medical Document, and that you have retained a copy of this document solely for your own records. Otherwise, we are pleased to accept the original paper version of the Medical Document directly from you or your patient, by mail.