**Toronto Compassion Centre (TCC)**
PO Box 65151 RPO Chester
Toronto ON M4K 3Z2
Website: www.tccentre.org
Email: membership@torontocompassioncentre.org
Fax: 416-323-0269
Non-Member Telephone: 416-668-6337

# Contact Information Sheet

Please print clearly.

First Name _____ Last Name _____

I prefer to be called (if different from legal name, optional) _____

Date of Birth (DD/MM/YYYY) _____/_____/_____ Male ____ / Female ____

Phone: Home _____ Alternate _____

Street Address _____

Mailing Address (if different) _____

City _____ Province _____ Postal Code _____

Email Address _____

Emergency Contact Name _____ Relation _____

Emergency Contact Phone Number _____

Doctor's Name _____ Phone Number _____

Doctor's Address (Street, City, etc.) _____

I was referred to TCC by _____ (Membership # _____)

Current medical diagnosis:_____

Allergies:_____

==========TCC STAFF USE==========
# _____ Orientation Date:_____

Date Confirmed _____ Doctor's Contact _____

H.C. _____ E.C. _____ O.I.C. _____



[updated January 15, 2016]

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# Doctor's Letter of Diagnosis

Your patient is requesting a letter of diagnosis from you on our behalf. You are not required to make any statements regarding dosage or safety of medicinal cannabis. Please fill in the following statement and stamp this page, or write a letter (on your letterhead) based on the information below.

Please keep a copy of this letter and the accompanying release of confidential medical information in your patient's file, as someone from the TCC will contact your office to verify the validity of the letter.

This letter must be current, documents older than 6 months will not be accepted.

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Patients Name, and Surname: _____

Patients Date of Birth: _____ (day) _____ (month) _____ (year)

This letter is to confirm that the above named individual has been diagnosed with,

_____

_____

I am a licensed Medical Doctor /Naturopathic Doctor **(circle one)** permitted to practice in the province of_____, Canada, andI am aware that my patient intends to access the services provided by Toronto Compassion Centre.

_____Stamp:

(Health Care Practitioner's original signature)

Date signed: _____

Written Name: _____

CPSO/Registration # _____

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## Release of Confidential Medical Information

We require the applicant to provide the TCC with a completed copy of this Release of Confidential Information. This form is to be filled out by the applicant and submitted with their application.

Date: _____/_____/_____ (DD/MM/YYYY)

I, _____ (patient name), do hereby grant permission for the release of my confidential medical information to the Toronto Compassion Centre. I give permission for the Doctor noted below to verify my medical status with a staff member of Toronto Compassion Centre by telephone or fax.

Toronto Compassion Centre agrees to use this information for the sole purpose of confirming the authenticity of medical documentation, and agrees to keep this information strictly private and confidential.

Patient's Signature: _____

Referring Doctor's name: _____(print)

Doctor's phone number: _____

Doctor's fax number: _____

## Personal Experience Questionnaire

**Please tell us about your previous experience with cannabis:**

- ☐ Currently use on a regular basis, familiar with various strains and methods of ingestion
- ☐ Tried it a few times recently
- ☐ "Not since I was a teenager"
- ☐ Never tried it, but have done research
- ☐ Have no previous knowledge

Comments:

_____

_____

_____

**Every person reacts differently to cannabis, and to individual strains.**
**Be an informed patient by researching your medicine.**