Request for approval for prescribing of medical cannabinoid by a licensed medical practitioner

All sections must be filled before the request is submitted.

Section A: To be filled by the medical practitioner

Brand name as displayed on the product label	Pharmaceutical Form/s & Route of administration	Name, Strength and/or concentration of each active ingredient in product and dose prescribed
How severe is patient's condition?	Reasons for request/Indications for use	
+ ☐ ++ ☐ +++ ☐ ++++ ☐	Medical Diagnosis & date of onset of medical condition: Diagnostic evidence of condition:	
Patient name & legally valid Identification Document No., Age, Address		
Medical Practitioner Name & contact telephone number		Medical Council Registration Number
Does patient suffer from mental illness? Yes ☐ No ☐		
If yes, has patient been reviewed by a psychiatrist? Yes ☐ No ☐		

I declare that:

- The above mentioned information is correct.
- I take full responsibility for the prescribing and monitoring and use of the product by the patient.
- I have reviewed previous treatment for this patient in the context of his/her condition and consider this product to be beneficial and considered that there is no viable alternative to such prescription. Previous treatment, of a duration of __ months, including the dosage regimen, was/is the following:

- I declare that I have fully informed the patient about the proper use of the product. The expected duration of treatment is ____ months.

Prescriber signature & rubber stamp: Date

This is the Official Medical Cannabinoid Application Form to be used ONLY by Licenced Medical Practitioners. All data collected is processed in accordance with the General Data Protection Regulation (EU) 2016/679. The health data can be used for statistics and research purposes in the interest of Public Health as provided by Article 9 (2) (j) of the General Data Protection Regulation (EU) 2016/679

Section B: To be filled in by the patient

I am aware that the product supplied to me is a medical cannabinoid and it has been explained to me by the medical practitioner in section A what such a product is.
Name and Signature of patient bearing legally valid Identification Document No.: Date:

Section C: To be filled in by the Pharmaceutical Unit, Superintendence of Public Health

Recommendations
An approval for the use of medical cannabinoids is ☐ recommended for a period of 6 months from approval date ☐ not recommended……..
Signature: Date:

Section D: To be filled by the Licensing Authority

I authorize prescriber/s in section A to prescribe medical cannabinoids for patient indicated in Section A.
Name and Signature: Date:

Requests are to be submitted by email to medicalpanel.sph@gov.mt
or by post to
Superintendence of Public Health: Sptar San Luqa, Pjazza San Luqa, Gwardamanġa PTA 1312

This is the Official Medical Cannabinoid Application Form to be used ONLY by Licenced Medical Practitioners. All data collected is processed in accordance with the General Data Protection Regulation (EU) 2016/679. The health data can be used for statistics and research purposes in the interest of Public Health as provided by Article 9 (2) (j) of the General Data Protection Regulation (EU) 2016/679