**Section 2085.EXHIBIT E Research Order for Delta-9-Tetrahydrocannabinol**

|  |  |  |
| --- | --- | --- |
|  |  |  |
|  |  |  |
|  |  |  |
| STATE OF ILLINOIS |  | **ORDER SERIAL** |
|  Blk PC Seal |  | **NUMBER** |
|  |  |
| *(Name of Hospital)* | No. |  |
|  |  |
| DANGEROUSDRUGSCOMMISSION(312) 822-9860 |  |  |
| *(Address & ZIP Code)* |  |
|  |  |
|  |  |
|  | *(Pharmacy DEA Number)* |  |
| RESEARCH ORDER FOR DELTA -9- TETRAHYDROCANNABINOL*Valid for ONE bottle of NOT MORE THAN 25 capsules at above pharmacy ONLY. ORDER NOT REFILLABLE.* |
|  |  |  |
| *PATIENT'S NAME:* |  | *DATE:* |  |
|  |  |  |
| *PATIENT'S ADDRESS:* |  | *ZIP:* |  |
|  |  |  |
| *PERIOD COVERED BY THIS ORDER:* |  | *198* | *TO* |  | *198* |
|  |  |  |
| *AGENT (if applicable):* |  |  |
|  |  |  |
| *ORDER:* | DELTA-9-THC AT |  | MGS | AT |  | CAPSULES, |
|  | *(Strength)* | *(Quantity written in longhand)* |
|  |  |  |
| SIG: | PATIENT IS TO RETURN UNUSED MEDICATION, |
|  |  |  |
|  |  |  |
| I AFFIRM THAT INFORMED PATIENT CONSENT HAS BEEN OBTAINED. |  |
|  |  |  |
|  |  |  | M.D. |
| *(Patient's Signature)* |  |  |  |
|  |  |  |
| M.D. ILL CONTROLLED SUBS NO: |  | M.D. FEDERAL DEA NO: |  |
|  |
|  |  |  |
| *DATE FILLED:* |  | *M.D. HOSPITAL AFFILIATION:* |  |
|  |  |  |
| *RECIPIENT'S**SIGNATURE:* |  | *VERIFICATION**OF RECIPIENT:* |  |
|  |  |  |
| *REG PHARMACIST'S**SIGNATURE & NUMBER:* |  |
| DDC FORM 299 (Series October 1980) Retain original in pharmacy; forward duplicate to DDC |