Medicinal Cannabis Referral

NY Medical Marijuana Certifications
TELEHEALTH OFFICE
Lockport, NY 14094
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Patients Name: _____ DOB: _____

Address: _____

Phone Number: _____

Patients Diagnosis: _____

Current Treatments and Medications: _____

_____

_____

Please indicate NYS Approved Indications (please select all that apply):

□Cancer □ALS (Lou Gehrig's dis.) □Parkinson's disease □HIV/AIDS □ PTSD
□Spinal Cord Injury with Spasticity □Inflammatory Bowel Disease □Huntington's disease
□ Opioid Use □ Chronic Pain □Multiple Sclerosis □Epilepsy □Neuropathies

Does patient have at least one of the following associated or complicating conditions in addition to an approved indication: (Must have to qualify?)

□Cachexia or wasting syndrome □Severe or chronic pain □Severe nausea
□Seizures □Severe or persistent muscle spasms □ PTSD □ Opioid Use

Referring Provider: _____

Date of Referral_____

Physicians Address: _____

Telephone: _____Fax:_____

Physicians Signature: _____

(Please Fax copy of last note with referral)