B.T.M Psychiatric NP Services, PLLC

11 W Prospect Ave, 3rd Fl.
Suite # 5B
Mount Vernon, NY 10550
Tel: 914-363-9299 ext 331 Fax: 914-243-1970
btmfamilypsych@gmail.com

Today's Date:_____

FULL Name:_____ DOB_____/_____/_____

Gender: Male_____ Female_____ TG_____ SS#_____-_____-_____

Martial Status: *(circle one) Widowed Single Married*

Email Address:_____

Address:_____ City,State, Zip_____

Telephone:(_____)_____-_____

VS: Ht: _____ Wt: _____ BP: _____ HR: _____ RR_____

Occupation:_____

Checklist: (You must have these things present in order to proceed)

Proof of address (utility bill and or current lease/mortgage)
NYS ID CARD
Documents from provider
Register: https://my.ny.gov/

Valid NY State ID Card: ID#/Expiration Date _____
(Copy will be obtained for records)

Proof of Address: _____

What medical condition(s) do you have that require medical marijuana?

_____

Why are you requesting Medical Marijuana?

_____

List Current Medications:_____

List Allergies:_____

(If Applies)
Are you currently Pregnant: YES_____ NO_____ **Breast Feeding:** YES_____ NO_____

First day of menstrual cycle: Month_____ DAY_____ YEAR____

Name of Doctor/Clinic/Hospital who diagnosed your condition:_____

Address of Clinic or Doctor:

_____

Date of last visit with Doctor:

_____

Are you currently on Federal Probation or Federal Parole? Yes_____ NO_____

If yes please explain:
_____

_____

Psychiatric History:

Do you have history of the following? If yes please explain.
Depression: Yes_____ No_____
Psychosis: (hearing, seeing or feeling things that are not there) Yes_____ No_____
Suicide Attempts: Yes_____ No_____
Suicidal Thoughts: Yes_____ No_____
Homicidal Attempts: Yes_____ No_____
Homicidal Thoughts: Yes_____ No_____
Medical or Surgical history: Yes_____ No_____
Substance Use History: Yes_____ No_____

The above information is True. I give permission to contact my above named provider who has given me the diagnosis/condition approved for medical marijuana treatment.

Patient's Signature _____ Date _____