Greene Family Medicine, APMC

MARIJUANA CONSULTATION REQUEST

Patient Name:_____ Date of Birth:_____

Dear Doctor:

Your patient is requesting our review of their medical history to determine if they are indicated for a recommendation for medical marijuana. Once we receive the information requested below, a review of their past medical history will be provided and a determination whether they will be accepted for the medical marijuana recommendation program can be completed. Your patient will require a statement from you as their treating medical provider that traditional and standard treatment has failed for their illness/condition.

Currently, the following are the only approved qualifying conditions our physicians will accept in this program:

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Please Check The Qualifying Condition: (PLEASE ✓)

- ☐ HIV/AIDS
- ☐ Cachexia/Wasting Syndrome
- ☐ Dystrophy/Multiple Sclerosis
- ☐ Seizures / Epilepsy (2 Standard Drugs Failed)
- ☐ Intractable (Chronic) Pain
- ☐ PTSD
- ☐ Cancer
- ☐ Spasticity
- ☐ Glaucoma
- ☐ Parkinson's Disease
- ☐ Crohn's Disease
- ☐ Autism Spectrum Disorder

We Request the Following Information: _____

A narrative synopsis addressing the issue(s) below is preferred in addition of medical records.

1. Copies of Medical Records Confirming Diagnosis and Failure of Treatment (up to past 6 months) **Do Not Send Entire Chart**

2. A current evaluation within last 30 days.

3. Present Diagnosis:_____ Date of Last Exam: _____

4. Past Diagnosis: (if applicable) _____

5. Symptoms / Other Limitations or Remarks (if applicable):_____

_____

6. List of All Maintenance Medications: (Please Attach List if Necessary)_____

_____

As the treating medical provider for this patient, I attest traditional / standard medication and treatment has failed in the care and symptoms of my patient.

_____ _____
Physician Signature Specialty

_____ _____
Physician Name (Please Print) Area Code - Phone Number

_____ _____ _____
Practice Address City State / Zip