Please return completed form to patient or fax to 877-331-0556, attention Gayle Roussel, APRN

Phone: 860-748-4318

Please be advised that I have diagnosed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_with the following debilitating medical condition(s):

Cancer

Positive Status for Human Immunodeficiency Virus or Acquired Immune

Deficiency Syndrome

Parkinson's Disease

Multiple Sclerosis

Damage to the Nervous Tissue of the Spinal Cord with Objective Neurological

Indication of Intractable Spasticity

Epilepsy

Cachexia

Wasting Syndrome

Crohn's Disease

Post-Traumatic Stress Disorder

Sickle Cell Disease

Post Laminectomy Syndrome with Chronic Radiculopathy

Severe Psoriasis and Psoriatic Arthritis

Amyotrophic Lateral Sclerosis

Ulcerative Colitis

Complex Regional Pain Syndrome, Type 1 and Type II

Cerebral Palsy

Cystic Fibrosis

Irreversible Spinal Cord Injury with Objective Neurological Indication of

Intractable Spasticity

Terminal Illness Requiring End-Of-Life Care

Uncontrolled Intractable Seizure Disorder

Spasticity or Neuropathic Pain Associated with Fibromyalgia

Severe Rheumatoid Arthritis

Post Herpetic Neuralgia

Hydrocephalus with Intractable Headache

Intractable Headache Syndromes

Neuropathic Facial Pain

Muscular Dystrophy

Osteogenesis Imperfecta

Chronic Neuropathic Pain Associated with Degenerative Spinal Disorders

Interstitial Cystitis

MALS Syndrome (Median Arcuate Ligament Syndrome)

Vulvodynia and Vulvar Burning

Intractable Neuropathic Pain that Is Unresponsive to Standard Medical

Treatments

Tourette Syndrome

Ehlers-Danlos Syndrome Associated with Chronic Pain

Chronic Pain of at least 6 months duration associated with the following

underlying chronic condition:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

which is refractory to other treatment interventions

Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_