



Dr. Cher Aymond, M.D.
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MARIJUANA CONSULTATION REQUEST

Web: chermd.net

Patient Name: _____ Date of Birth: _____ Phone: _____

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:

Please Check The Qualifying Condition: (PLEASE ✓)

- | | |
|--|--|
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Cachexia/Wasting Syndrome | <input type="checkbox"/> Spasticity |
| <input type="checkbox"/> Dystrophy/Multiple Sclerosis | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Seizures / Epilepsy (2 Standard Drugs Failed) | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Intractable (Chronic) Pain | <input type="checkbox"/> Crohn's Disease |
| PTSD | others : |

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