Well medica
Your health comes first

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Medical Marijuana Therapy Assessment Referral Form

Patient name: _____ Patient address: _____

Date of birth: _____ _____

Health card #: _____ Home/cell phone: _____ /_____

Patients with the following conditions and or symptoms may be referred for assessment:

- □ Nausea and vomiting (chemotherapy and non-chemotherapy associated)
- □ Wasting syndrome and loss of appetite in AIDS and cancer patients (stimulate appetite and produce weight gain)
- □ Anorexia nervosa
- □ Multiple sclerosis, amyotrophic lateral sclerosis, spinal cord injury
- □ Epilepsy and seizures
- □ Acute pain (acute pain or post-operative pain)
- □ Chronic pain (neuropathic pain or chronic non-cancer pain)
- □ Cancer pain
- □ Headache and migraine
- □ Musculoskeletal disorders (osteoarthritis, fibromyalgia, rheumatoid arthritis, osteoporosis)
- □ Movement disorders (dystonia, Huntington's and Parkinson's diseases, Tourette's syndrome)
- □ Glaucoma
- □ Psychiatric disorders, except schizophrenia (anxiety and depression, sleep disorders, post-traumatic stress disorders, alcohol and opioid withdrawal symptoms)
- □ Alzheimer's disease and dementia
- □ Inflammatory skin diseases
- □ Gastrointestinal system disorders (irritable bowel syndrome, inflammatory bowel diseases, diseases of the liver, metabolic syndrome, obesity, diabetes, diseases of the pancreas)

Patients who may benefit from Medical Marijuana therapy will be provided with consultation.

Reason for Referral (required):

_____

_____

_____

Name of Referring MD: _____ Signature of referring MD: _____

Referring MD billing #: _____ Date of Referral: _____

Our office will contact the patient to make an appointment date.
Please attach all relevant imaging, blood work and or consults.