

**Apple Ridge Family Medicine
Medical Marijuana Referral Form
Physician office to complete form**

Patient Name: _____ DOB: _____

I, _____, (**Print Physician's name here**) am referring my patient for medical marijuana certification. The patient is under my care for one or more of the following qualifying conditions and if needed I am able to produce medical records confirming the diagnosis. (**Circle one**)

- | | | |
|-----------------------------------|--------------------|-------------------------------|
| Autism | Multiple Sclerosis | Neuropathy |
| Cancer | | Opiate Dependence |
| Chronic Pain | HIV | Parkinson's |
| Crohns/Inflammatory Bowel Disease | PTSD | Epilepsy/Spastic Movement D/O |
| Anxiety | Other | Tourette's Syndrome |

Please direct patient to our website to complete application process. We will contact the patient to schedule upon completion of online form. Hard copies available upon request.

WWW.KINDMDPA.COM

Referrals will only be accepted from the physician's office fax. No hand carried referrals accepted. We do not require records but reserve the right to ask for them if needed.

PATIENT NEEDS TO BE REGISTERED WITH THE STATE HEALTH DEPARTMENT PRIOR TO CERTIFICATION APPLICATION.

WWW.MEDICALMARIJUANA.PA.GOV

X _____

Provider Signature

Name of office and address (stamp is acceptable)

Office Phone Number: _____

Please forward demographics along with this referral. FAX 717 338 9070