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

Patient Name :_____

Patient Phone number : ( ) - 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