MCTC

MEDICAL CANNABIS TREATMENT CENTER OF HOLLYWOOD

REFERRING PROVIDER	
PRACTICE:	REFERRING DOCTOR/NP/PA:
ADDRESS:	CITY: STATE:
PH: FAX:	EMAIL:
PATIENT INFORMATION	
PATIENT NAME:	DOB: PH:

CANNABIS CONSULTATION REQUEST DIAGNOSIS	
☐ CANCER	☐ MEDICAL CONDITION COMPARABLE TO THOSE LISTED ON THE LEFT. PLEASE SPECIFY: _____
☐ EPILEPSY	☐ POST-TRAUMATIC STRESS DISORDER (PTSD)
☐ GLAUCOMA	☐ AMYOTROPHIC LATERAL SCLEROSIS (ALS)
☐ HIV/AIDS	☐ TERMINAL CONDITION:_____
☐ CROHN'S DISEASE	☐ CHRONIC NONMALIGNANT PAIN THAT PERSISTS BEYOND THE USUAL COURSE OF A QUALIFYING MEDICAL CONDITION:_____
☐ PARKINSON'S DISEASE	
☐ MULTIPLE SCLEROSIS (MS)	

REFERRING PHYSICIAN'S SIGNATURE_____MD DO NP PA DC

THIS FORM IS REQUIRED FOR YOUR INITIAL VISIT. PLEASE HAVE YOUR DOCTOR FILL OUT AND FAX FORM TO (954) 272-0676 OR BRING TO YOUR APPOINTMENT. ANY QUESTIONS CALL (954) 381-7644