DENT NEUROLOGIC INSTITUTE 1963

DENT
CANNABIS CENTER

FAX TO: 716.819.3814

DENT Cannabis Clinic
3980 Sheridan Drive
Amherst NY, 14226
www.dentinstitute.com
(716) 250-2000

REFERRAL FOR MEDICAL CANNABIS ASSESSMENT

***Is this related to an open WC case?* ☐ Yes ☐ No

FULL NAME_____ **INSURANCE**_____

ADDRESS_____ **DATE OF BIRTH**_____

CITY/ZIP CODE_____ **PHONE**_____

NYS Approved Indications (please select all that apply):

☐Cancer ☐ALS *(Lou Gehrig's dis.)* ☐Parkinson's disease ☐Multiple Sclerosis ☐Spinal Cord Injury with Spasticity
☐HIV/AIDS ☐Epilepsy ☐Inflammatory Bowel Disease ☐Neuropathies ☐Huntington's disease
☐ Chronic Pain ☐ PTSD ☐ Opioid Replacement ☐ Substance Use Disorder

Must have at least one of the following associated or complicating conditions in addition to an approved indication:

☐Cachexia or wasting syndrome ☐Severe or chronic pain ☐Severe nausea
☐Seizures ☐Severe or persistent muscle spasms ☐ PTSD ☐ Opioid Use (must be in article 32 treatment program)

Please note that if you do not have at least one indication from both boxes marked, patient will not be able to be evaluated for Medical Cannabis

PATIENT DIAGNOSIS AND SYMPTOMS:

PREVIOUS & CURRENT TREATMENTS / SURGERIES / MEDICATIONS:

This form must be signed by the treating physician and must have records and testing results faxed along with it

Referring Physician
Full Name: _____ Referral Date: _____

Address: _____ Telephone: _____

PHYSICIAN SIGNATURE_____

YOUR PATIENT WILL BE CONTACTED DIRECTLY TO SCHEDULE AN APPOINTMENT ONCE ALL INFORMATION IS RECEIVED AND REVIEWED BY THE MEDICAL DIRECTOR
****Please note there may be a wait time to schedule due to referral volume****