



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
- Pain that degrades health and functional capability where the use of medical marijuana is an alternate to opioid use

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 Disorder

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****