Medical Marijuana Clinician Referral Form
(Fax or Electronic Submission Only)

Recommendation Date (DD/MM/YYYY): _____

Expiration Date (*Must be 36 Months After recommendation date):_____

Patient Information			
First Name	MI	Last Name	Suffix
Street Number and Street Name			
Unit Number	Phone		
City	State	Zip Code	
Date of Birth (MM/DD/YYYY)	Under the age of 18? Yes ☐ No ☐	Physically Disabled? Yes ☐ No ☐	

ICD-10 Code or Name of Condition for which Therapeutic Cannabis Treatment is Recommended
(Louisiana law allows for any condition considered debilitating to an individual patient.)

***Optional. If applicable, please list of any dosage forms of marijuana that may be contraindicated by the patient's debilitating condition or co-morbidities**

Authorized Clinician Information			
First Name	MI	Last Name	Suffix
Street Number and Street Name		Unit Number	
City, State, Zip			
Phone Number	Fax Number	NPI Number	
I certify that I am currently in good standing with either the Louisiana State Board of Medical Examiners, or the Louisiana State Board of Nursing as applicable and required by LA R.S. 40:1046(B). I further affirmatively state that if I am a Nurse Practitioner, that I have prescriptive authority conferred by the Louisiana State Board of Nursing. Signature:			Date

Note: This form contains the basic data elements defined by the Louisiana Department of Health in LAC Title 51 Part XXIX Subpart 2