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

Patient Information					
First Name	MI	Last Name		Suffix	
Street Number and Street Name	(or PO Box)				
Unit Number	Phone	Phone			
City	State		Zip Code		
Date of Birth (MM/DD/YYYY)	Under the Yes	e age of 18?	Physically Disabled Yes	? No 🗌	
			·		
ICD-10 Code or Description of	Condition				
(Louisiana law allows for any co	ondition considered d	lebilitating to an individual	patient.)		
Therapeutic Marijuana Treatn	nent Requested				
	•				
(D 1 . 11	C 1.4 C	1	to to division dia matematica di	D. 1 C 1	
(Request shall expire one year a dosage are not required.)	fter date of issue unle	ess a shorter period of time	is indicated by the physicia	in. Product form and	
Physician Information					
First Name	MI	Last Name		Suffix	
Address					
City, State, Zip		<u> </u>			
		-			
Phone Number	Fax Number	NPI N	NPI Number		
_		icense to practice medicine issued	d by the Louisiana State Board	Date	
of Medical Examir	ners				

Note: This form contains the basic data elements defined by the Louisiana Board of Pharmacy in LAC 46:LIII.2457