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		
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 Description of Condition
(Louisiana law allows for any condition considered debilitating to an individual patient.)

Therapeutic Marijuana Treatment Requested
(Request shall expire one year after date of issue unless a shorter period of time is indicated by the physician. Product form and dosage are not required.)

Physician Information			
First Name	MI	Last Name	Suffix
Address			
City, State, Zip			
Phone Number	Fax Number	NPI Number	
Signature I attest that I hold a current and unrestricted license to practice medicine issued by the Louisiana State Board of Medical Examiners			Date

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