2839 St. Rose Parkway, Suite #130
Henderson, Nevada 89052

PATIENT REFERRAL FORM

Fax to: (702) 906-0202

Date: ____________________

PATIENTS INFORMATION

Last Name:	First Name:	Middle Initial:

Date of Birth:	Address:

Home Phone:	Mobile Phone:	Email:

Primary Reason for Referral: (Check one)

- ❏ *AIDS*
- ❏ *Cancer*
- ❏ *Glaucoma*
- ❏ *Post-Traumatic Stress Disorder (PTSD)*
- ❏ *Cachexia (wasting and malnutrition associated with chronic disease)*
- ❏ *Persistent Muscle Spasms (including Multiple Sclerosis)*
- ❏ *Seizures (including Epilepsy)*
- ❏ *Severe Nausea*
- ❏ *Severe Pain*
- ❏ *others:* ____________________

Current Medical Conditions:

Medications and Allergies:

Please attach appropriate medical records

Referring Physician Name	Referring Physician Signature	Date

Phone number: ______________________________ Fax: ______________________________

Address: ______________________________ Email: ______________________________

"The physicians at Valley Center for Cannabis Therapy are committed to improving the lives of patients by providing access to the responsible use of medical cannabis"