The Healing Clinics
151 Jeff Davis Blvd, Ste B
Natchez, MS 39120
Phone: 601-653-0510 - Fax 215-405-2957

Physician Referral Form
18 to 25 Years of Age

Patient Name:_____

Patient DOB:_____ Gender: _____

Patient Telephone No:_____Patient Email: _____

Patient Street Address:_____

City, State:_____ Zip Code:_____

*I am recommending the referenced patient above, who is between the ages of 18 and 25, for medical Marijuana based on the below selected, Mississippi qualifying condition(s).

Mississippi Debilitating Conditions that Qualify for Medical Marijuana
Check all that Apply

_____ **cancer**	_____ **ulcerative colitis**	**Also qualifying is a chronic terminal or debilitating disease or medical condition or its treatment that produces one or more of the following:**
_____ **Parkinson's disease**	_____ **sickle-cell anemia**	
_____ **Huntington's disease**	_____ **Alzheimer's disease**	
_____ **muscular dystrophy**	_____ **agitation of dementia**	
_____ **glaucoma**	_____ **post-traumatic stress disorder (PTSD)**	
_____ **spastic quadriplegia**	_____ **autism**	
_____ **positive status for human immunodeficiency virus (HIV)**	_____ **pain refractory to appropriate opioid management**	_____ **cachexia or wasting syndrome**
_____ **acquired immune deficiency syndrome (AIDS)**	_____ **diabetic/peripheral neuropathy**	_____ **chronic pain**
_____ **hepatitis**	_____ **spinal cord disease or severe injury**	_____ **severe or intractable nausea**
_____ **amyotrophic lateral sclerosis (ALS)**	_____ **other (list below)**	_____ **seizures**
_____ **Crohn's disease**		_____ **persistent muscle**

Date(s) of Treatment: _____to _____

Type(s) of Treatment: _____

_____

_____

Physician Name:_____

Physician Address:_____

Physician Phone Number:_____

Physician Signature:_____Date:_____