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

## Physician Referral Form
## 25 Years of Age OR Older

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 over the age of 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:_________________