AYSEV
COMPREHENSIVE CANNABINOID CARE

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561-570-5500
By Appointment Only
Fax 450-9934

Patient Name: _____

Patient Phone Number: _____

❑ Please contact the patient. ❑ They wish to reach out to you.

REFERRING DIAGNOSIS: (Please check all that apply)

❑ Amyotrophic Lateral Sclerosis
❑ Cancer: type/stage: _____
❑ Crohn's Disease
❑ Epilepsy
❑ Glaucoma
❑ Hepatitis C
❑ HIV/AIDS
❑ Multiple Sclerosis
❑ Parkinson's Disease
❑ Post Traumatic Stress Disorder (PTSD)

❑ Chronic non-malignant pain caused by a qualifying medical condition or that originates from a qualifying medical condition and persists beyond the usual course of that qualifying medical condition

❑ Medical conditions of the same kind or class as or comparable to those above: _____

❑ Terminal Diagnosis: _____

❑ Other: _____

❑ **Referring physician:** I have discussed the options with the patient and I believe that the benefits outway the risks, please review with the patient in further depth.

Referring Physician _____

Signature _____

Please fax the most recent note confirming the referring diagnosis to (561) 450-9934 or email is at AysevCBD@gmail.com.

THE BEST
FIRST PLACE TO START IS
AYSEVCBD.COM