Medical Marijuana Visiting Qualified Patient Form

Patient Information			
Patient First Name	MI	Patient Last Name	Suffix
Street Number and Street Name (or PO Box)			
Unit Number	Patient Phone Number		
City	State	Zip Code	
Date of Birth (MM/DD/YYYY)	Under the age of 18? ☐ Yes ☐ No	Physically Disabled? ☐ Yes ☐ No	

Attestation: I attest/certify that I have been diagnosed by a licensed physician with the debilitating medical condition listed below. I attest that I hold an active and valid medical marijuana registry card (or its equivalent) in another state district, territory, commonwealth, or insular possession of the United States. I further attest that I will not divert any medical marijuana dispensed by a Louisiana Marijuana Pharmacy to any person.

Please select: ☐ Yes ☐ No

Date

Signature:

ICD-10 Diagnosis Code or Description of Debilitating Medical Condition
Debilitating Medical Condition has the meaning ascribed in R.S. 40:1046(A)(2)(a)

Therapeutic Marijuana Treatment Requested

Medical Provider and Registry Information			
Provider First Name	MI	Provider Last Name	Suffix
Provider Address		National Provider Identifier Number (NPI)	
City, State, Zip			
Provider Phone Number	Provider Fax Number	Medical Marijuana Recommendation Expiration Date	
State of Issuance	Medical Marijuana Patient Registry ID Number (or equivalent)		

Note: This form contains the basic data elements defined by the Act No. 438