



Referral Form

Mental Health Medical Cannabis

*Referrals are NOT required for patients to be evaluated for medical cannabis within our clinic. However, this form when accompanied with the requested information below will help secure the most productive evaluation at the time of service. **

Please:

- Complete and sign this referral form
- Send a copy of the completed referral form with medical records to our office by fax.
Pause Pain & Wellness Fax Number: 833.707.2400
- Give a copy of the referral form to the patient

This referral is good only for 30 days from the date of service.

Patient name: (Last) _____ (First) _____ (Middle) _____

Patient date of birth: _____ Patient Contact Number: _____

Patient address: _____

Patient city: _____ State: _____ Zip code: _____

Patient Practitioner making referral: _____

Practitioner phone number: _____

Practitioner address: _____

Practitioner National Provider Identifier (NPI) number: _____

Practitioner signature: _____

Date of signature: _____ Date of service: _____

Patient relevant Dx: _____

Preferred location:

___ Oxford ___ Tupelo ___ Starkville ___ Olive Branch

___ Hattiesburg ___ Gulfport ___ Meridian ___ Jackson/Flowood