Patient Referral Form

Please fax this form to The THC Clinic at (203)886-1188

Patient Name: _____

Date of Birth: _____ Patient's Phone: _____

Address: _____

City/State/Zip: _____

Patient Email Address (needed to certify for medical marijuana):

_____

Qualifying Condition (Please attach records with diagnosis): _____

_____

Referred by:

Physician's name (please print):_ First Middle Last

Physician's signature: _____

UPIN: _____ NPI: _____Phone: _____

Address: _____

City, State, Zip: _____

Referral Date: _____ Date of Office Visit: _____

How did you hear about The THC Clinic: _____

Questions? Contact our office at (203)530-5566

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