Pain Therapy Associates

Providing Access to Medical Marijuana Evaluations & Certifications

DIAGNOSIS FORM – to be completed by a Physician

Date: ____

Patient's Name: ____

Date of Birth: ____

Patient's Diagnosis: ____

Patient's Symptoms: ____

Under the rules of the New York Compassionate Care Act, patients are eligible to use medical marijuana if they have one or more of the following approved medical conditions:

Active or Recurrent Cancer
Positive status for HIV or AIDS
Amyotrophic Lateral Sclerosis (ALS) or Lou Gehrig's disease
Parkinson's disease
Huntington's disease
Multiple Sclerosis
Damage to the nervous tissue of the spinal cord with objective neurological indication of intractable spasticity
Epilepsy
Chronic Pain
PTSD
Inflammatory Bowel Disease: Crohn's disease, ulcerative colitis
Various neuropathic disorders: peripheral, diabetic, cranial (optic, auditory), autonomic, small fiber neuropathy (SFN) often associated with fibromyalgia & focal neuropathy

AND diagnosed with
any of the following symptoms where it is clinically associated with a complication or its treatment: cachexia or wasting syndrome, severe or chronic pain, symptoms of PTSD, neuropathy, severe nausea, seizures, and severe or persistent muscle spasms.

I am a licensed practitioner.
I attest, to the best of my knowledge, the above information is accurate and true.

Physician's Name: (print) ____

Physician's Signature: ____

To be valid, this form must contain the physician's handwritten signature.