MEDICAL CANNABIS 2nd PHYSICIAN REFERRAL FORM
REQUIREMENT: FLORIDA DEPARTMENT OF HEALTH
OFFICE OF MEDICAL MARIJUANA USE
ExAlt Med
Office of Eric J Exelbert MD

The Florida Department of Health has strict physician and patient requirements in order to qualify for medical cannabis registration and ultimately a medical cannabis card. As a qualifying physician, Dr. Eric J Exelbert must comply with the State's requirements both to protect the patient and my medical license. The prerequisites for a patient to be qualified are:

- Physical examination while present in the same room as the patient
- Full assessment of patient's medical history
- Diagnose patient with a qualifying condition
- Determine the medical use of marijuana likely outweighs health risks and document that in the record.
- For patients under 18 years of age, have a second physician agree in writing that medical use of marijuana likely outweighs the health risks for that minor patient.
- Determine if the patient is pregnant. If the patient is pregnant, it must be documented in that patient's medical record and only low-THC cannabis certification can be given to that patient during the pregnancy.
- Review the patient's history in the PDMP database
- Confirm the patient does not already have an active certification from another physician in the Medical Marijuana Use Registry.
- Physician must register as the physician issuing the certification to that qualified patient in the registry.
- Obtain voluntary and informed written consent each time a physician certification is provided to the patient and keep that with the patient's medical record. The approved informed consent form containing all legal requirements is available from the Board of Medicine and Board of Osteopathic Medicine.

Your signature at the bottom of this form serves as documentation that you are a second physician that agrees that the use of medical marijuana outweighs the health risk for this minor patient.

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Signature of MD or DO Physician **Printed Name of MD or DO Physician**

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Date of Signature **Name of Patient and Date of Birth**

Please return with the patient listed above or scan and email to exaltmed@gmail.com.