MEDICAL CANNABIS REFERRAL FORM

CONFIDENTIAL FACSIMILE TRANSMITTAL SHEET

Last name: _____ First name: _____

DOB: _____ Gender: _____

Phone number: _____

Diagnosis: _____

Please fax this request along with a letter or one page from the patient's medical record that lists the primary diagnosis being considered for certification.

PLEASE NOTE OUR NEW FAX NUMBER: 808-468-1470

Thank you,

Clifton Otto, MD

For your reference, the qualifying conditions for Hawaii's Medical Cannabis Program are currently: ALS, Cachexia, Cancer, Glaucoma, HIV/AIDS, Lupus, Multiple sclerosis, PTSD, Rheumatoid arthritis, Seizures/Epilepsy, Severe muscle spasms, Severe nausea, Severe pain.

Please note there is no CMS code for Medical Cannabis Consultation, so this form is primarily for your internal tracking. Updated: 30Mar22

Akamai Cannabis Consulting – 3615 Harding Ave, Suite 304, Honolulu, HI 96816
Tel: 808-233-8267, Fax: 808-468-1470