MEDICAL CANNABIS
SERVICES AUSTRALIA

PLEASE FAX THIS FORM TO:
XXXXXXXXXX

DOCTOR REFERRAL FORM

PATIENT DETAILS

FULL NAME: ______________________ DOB (DD/MM/YY): ______________________

PHONE NUMBER: ______________________ EMAIL: ______________________

ADDRESS: ______________________ MEDICARE NUMBER: ______________________

PRACTITIONER DETAILS

PRACTICE STAMP:

OR

FULL NAME: ______________________ HEALTH PRACTITIONER TYPE: ______________________

PHONE NUMBER: ______________________ FAX NUMBER: ______________________

PRINCIPAL PRACTICE ADDRESS: ______________________

PROVIDER NUMBER: ______________________ ARGUS / HEALTHLINK NUMBER: ______________________

REFERRAL DETAILS

Indication / Symptom to be treated with Medicinal Cannabis: ______________________

Medical condition causing this symptom: ______________________

Please tick all that apply:

- ❑ I support the use of Medicinal Cannabis for this patient.
  - if unticked, please specify reasoning ______________________
- ❑ Patient has tried or is unable to use registered medications for this indication
- ❑ Patient health summary [Required]. Please include: Past and current medical history and current medications and past medications trialled for above indication.
- ❑ I am aware that medicinal cannabis products containing THC are generally not appropriate for patients who: have a previous psychotic or concurrent active mood or anxiety disorder; are pregnant, planning on becoming pregnant, or breastfeeding; and/or have unstable cardiovas cular disease.

I hereby refer the above named patient to a doctor and/or specialist at Medical Cannabis Services.

PRACTITIONER SIGNATURE: ______________________ DATE (DD/MM/YY): ______________________

Please contact info@medicalcannabisservices.au or XXXXXXXXXXX for all inquiries