Medical Cannabis Services
P1 800 845 197 **F** 1 800 845 129
info@medicalcannabisservices.com.au
www.**medicalcannabisservices**.com.au

Patient Referral Form

Patient Details

Full Name: ____________________ DOB (DD/MM/YY): ____ / ____ / ____

Phone Number: ____________________ Email: ____________________

Address: ____________________ Medicare Number: ____________________

Practitioner Stamp/Practitioner Details

Referral Details

Indication to be treated with Medicinal Cannabis: ____________________

- [ ] I have discussed all registered/conventional options with the patient for the indication.
- [ ] Patient health summary[Required]. (Please include past and current medical history and current medications and past medications trialled for above indication.)

I hereby refer the above named patient to a doctor at **Medical Cannabis Services** for assessment of suitability for medicinal cannabis.

Practitioner Signature: ____________________ Date (DD/MM/YY): ____ ____ ____

Please attach health summary/medical history and fax this form to: 1800 845 129