Referral for Medical Cannabis Assessment

AUSTRALIAN CANNABIS CLINICS

Email form to: info@auscannabisclinics.com.au *OR* fax to: 02 8331 5703

Patient Details

FIRST AND LAST NAME

DOB (DD/MM/YY)

MEDICARE NUMBER

PHONE NUMBER

EMAIL ADDRESS

ADDRESS

Health Details

Primary Diagnosis/Condition

Symptoms to be treated

Current medications

Past medications trialled

Please include the patient's medical records relevant to the condition/symptoms of interest and fax to:

02 8331 5703

or

email to:

info@auscannabisclinics.com.au

Referring Doctor Details

DOCTOR'S NAME

PROVIDER NUMBER

PRACTITIONER TYPE

HEALTHLINK NUMBER

PRACTICE ADDRESS

PHONE

FAX

EMAIL ADDRESS

REFERRING DOCTOR'S SIGNATURE

DATE

Your patient will be contacted directly to schedule an appointment. A consultation report will be provided outlining the treatment plan after the appointment.