

Referral for Medical Cannabis Assessment

Patient Details

FIRST AND LAST NAME	DOB (DD/MM/YY)	MEDICARE NUMBER
PHONE NUMBER	EMAIL ADDRESS	
ADDRESS		

Health Details

Symptom to be treated with medical cannabis

Primary diagnosis/condition causing symptom

Current medications treating symptom	Past medications trialled for symptom

Referring Doctor's Stamp/Details

	DOCTOR'S SIGNATURE
	DATE

- The patient has exhausted all registered/conventional options for the indication above.
- I have attached the **Patient's Health Summary (Required)** including past and current medical history, past and current medications trialled for above symptom and a list of treating physicians.

Please **fax to: 02 8331 5703** or email to: info@acclinics.com.au. Your patient will be contacted directly to schedule an appointment. A consultation report will be provided outlining the treatment plan after the appointment.