This form, when completed, will be classified as **strictly confidential**.
For guidance on how we use this information please see our privacy policy found at https://cannadoc.com.au/privacy.

Patient History & Referral Form

Dear Doctor,

Your patient has approached Cannadoc Health with enquiries about the use of medicinal cannabis in the treatment of their medical condition/s. Our clinic specialises in providing patient education and where appropriate, access to medicinal cannabis.

At your convenience, please complete the form below and include information you feel would benefit this patient in relation to their consultation. With your approval, we will then schedule an appointment at one of our special access clinics for your patient. If treatment is commenced, we will provide further updates as appropriate.

This form can also be found online at www.cannadoc.com.au/referral and sent to info@cannadoc.com.au or faxed to 03 9923 6860.

Yours sincerely,

Cannadoc Doctors

TREATING PROVIDER DETAILS	PATIENT DETAILS
Name:	Name:
Address/Clinic Details:	Address:
Provider #:	DOB:
How did you hear about us:	Phone:
	Email:

Patients Symptoms (please check):

- ☐ Chronic pain
- ☐ Anxiety
- ☐ Spasticity
- ☐ Nausea/Vomiting in chemotherapy
- ☐ Sleep problems
- ☐ Seizures
- ☐ Other _____

Condition causing these symptoms:

Do you have any concerns with this patient using medicinal cannabis?

- ☐ Yes (please describe) _____
- ☐ No

Is the patient currently on medication for these symptoms?

- ☐ Yes (please list/attach history, including dosage) _____
- ☐ No

Please included the patient's health summary.

- ☐ Yes

Treating Provider Signature/Stamp:_____**Date:** _____

***Please return this form by scan to info@cannadoc.com.au or by fax to 03 9923 6860.**