Referral Form & Patient History

Dear Doctor,

At Cannadoc Health, our clinic specialises in providing patient education and where appropriate, access to medicinal cannabis for the treatment of their medical condition/s.

Please complete the Referral Form below and accompanied by the Patients Health Summary and send to our Email: Referral@cannadoc.com.au or Fax: 03 9923 6860

Yours sincerely,

Cannadoc Doctors

This form can also be found online at www.cannadoc.com.au/referral

Website: www.cannadoc.com.au/ Phone: 1300 944 033

TREATING PROVIDER DETAILS	**PATIENT DETAILS**
Name:	Name:
Address/Clinic Details:	Address:
Provider #: Email:	DOB:
How did you hear about us: ☐ Google/Engine Search ☐ Social Media ☐ Newsletter/Flyer ☐ Referred	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? *E.g Mental Health Illness*

- ☐ Yes (please describe) _____
- ☐ No

Is the patient currently on medication for these symptoms?

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

Please include the Patient's Health Summary (Required for Consultation)

- ☐ Yes it is attached

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

***Please send this form and Patient Health Summary by email to Referral@cannadoc.com.au or Fax: 03 9923 6860**

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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.