

PATIENT'S PERSONAL DETAILS

Title: _____ First Name: _____ Last Name: _____

DOB: _____ Gender: Female Male Other

Phone: _____ Email: _____

Address: _____

State: _____ Postcode: _____

Medicare Number: _____ Ref no: _____ Medicare Expiry: _____

PERSONAL HISTORY DETAILS

Does the patient suffer of any of these conditions?

- | | |
|---|--|
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> PTSD |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> CINV (Chemotherapy Induced Nausea and Vomiting) |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Arthritis |

Other. Please Specify: _____

Please list all past medications for the patient and length tried:

Reason for referral: _____

Does your patient have a current Care Plan in place? Yes No

Would you like us to do a Care Plan review for your patient? Yes No

If your patient does not have a current Care Plan in place would you consent for our NCC doctor to initiate one? Yes No

PRACTITIONER DETAILS

PRACTICE STAMP

OR

Full Name: _____ Practitioner Type: _____

Phone: _____ Email: _____

Address: _____

Provider Number: _____ Healthlink Number: _____

REFERRAL DETAILS

I support this Patient to be treated with Medicinal Cannabis if needed.

I hereby refer the above-named patient to a doctor and/or specialist at National Cannabinoid Clinics.

Practitioner Signature _____ Date (DD/MM/YY) _____