NEW PATIENT FORM

Return by email: info@ncclinics.com
Or Fax: (02) 8080 8113

PERSONAL DETAILS

Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master Other – Please specify: ____________________

Surname:______________________________Given Name(s): ______________________________

Preferred Name(if different to above):______________________________DOB: ____________________

Gender: ☐ Female ☐ Male ☐ Other

Aboriginal or Torres Strait Islander: ☐ Yes Occupation: ____________________

Address:____

Suburb:____________________State:____________________Postcode: ____________________

Home Phone:______________________________Work Phone: ______________________________

Mobile:______________________________Email: ______________________________

Medicare Card No:______________________________Ref no:________Expiry Date:____________________

DVA No:______________________________Expiry Date:______________________________

Native Language:____

If other than English, will you require a certified translator? Which language: ______________________________

Please provide below two emergency contacts (if possible).

Emergency Contact:______________________________Relationship: ____________________

Ph Number:______________________________

Emergency Contact:______________________________Relationship: ____________________

Ph Number: ______________________________

Employment Status:

☐ Full Time Employed ☐ Unemployed ☐ Self Employed ☐ Full Time Student

☐ Part Time Employed ☐ Retired ☐ Part Time Student ☐ Other

NATIONAL CANNABINOID CLINICS

NEW PATIENT FORM

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PERSONAL MEDICAL HISTORY

Do you currently experience, or have a history of, any of the following medical conditions? Please tick all that apply.

- ☐ Chronic Pain
- ☐ PTSD (Post Traumatic Stress Disorder)
- ☐ Multiple Sclerosis
- ☐ Fibromyalgia
- ☐ Crohn's Disease
- ☐ CINV (Chemotherapy Induced Nausea and Vomiting)
- ☐ Stress
- ☐ Seizures
- ☐ Anxiety
- ☐ Insomnia
- ☐ Arthritis
- ☐ Depression
- ☐ Gastrointestinal Disorder
- ☐ Other? Please specify

Please tick the ones you have a history of or are currently experiencing:

- ☐ Active Psychosis
- ☐ Mood Disorder
- ☐ Cardio Pulmonary Disease
- ☐ Anxiety
- ☐ Drug dependence or substance abuse
- ☐ Bipolar Disorder

Please list all past medications taken for your conditions and length of time taken or trialed.

Name of medication: ________________________ Length of time: ____

Name of medication: ________________________ Length of time: ____

Name of medication: ________________________ Length of time: ____

Name of medication: ________________________ Length of time: ____

Do you have any known allergies? Please list: ____

____

____

Are you currently pregnant, planning to become pregnant or breastfeeding? ____________________

Smoking status: ☐ Non-smoker ☐ Ex-smoker ☐ Smoker, number per day: ____________________

Do you drink alcohol? ☐ Yes ☐ No If yes, how many standard drinks per week ____________________

When did you last have an overall check-up? Date:______________________________ ☐ Unsure ☐ Never

NEW PATIENT FORM

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Are you currently driving? ☐ Yes ☐ No

Do you want to continue driving? ☐ Yes ☐ No

ADDITIONAL INFORMATION

Please list all current medical and specialist practitioners that you are under the care of in the space below.

Practitioner name:________________________________Specialty: ____________________

Phone: ____________________________________

Practice Address: ____

Approximate date of lastconsultation: ____

Practitioner name:________________________________Specialty: ____________________

Phone: ____________________________________

Practice Address: ____

Approximate date of lastconsultation: ____

Practitioner name:________________________________Specialty: ____________________

Phone: ____________________________________

Practice Address: ____

Approximate date of lastconsultation: ____

Direct Marketing : NCC may use your information so that we can promote and market to your health related products and services that we think will be of interest to you. To opt-out of this type of marketing, please follow the steps outlined in one of our marketing communications.

☐ I would like to receive marketing material

☐ I would not like to receive marketing material

NATIONAL CANNABINOID CLINICS

Return by email: info@ncclinics.com Or Fax: (02) 8080 811

By submitting this form:

☐ I agree to allow National Cannabinoid Clinic to access your medical history records if needed.

☐ I understand that assessment by our doctors does not ensure approval and access to medicinal cannabis.

☐ I agree to the privacy policy stated at https://ncclinics.com.au/ncc-privacy-policy

☐ I consent to email communications as per https://ncclinics.com.au/ncc-email-consent

☐ I accept NCC terms and conditions shown at https://ncclinics.com.au/ncc-terms-and-conditions

Patient FullName: ______________________________

Patient Signature: ______________________________ Date (DD/MM/YY) ______________

In the instance that you are not able to physically provide a signature then a substitute decision maker may step in. If you have signed the above declaration, then you can ignore this section. The signature below indicates that the patient has agreed to the above declaration.

Source of decision-making authority (Tick one):

☐ Patients own consent

☐ Tribunal Appointed Guardian

☐ Attorney/s for Health matters Enduring Power of Attorney or Advice Health Directive

☐ Statutory Health Attorney

If none of the above, the adult guardian had provided consent

Decision Maker Name: ______________________________ Relation: ______________

Decision Maker Signature: ______________________________ Date: ______________

Witness Name: ______________________________ Relation: ______________

Witness Signature: ______________________________ Date: ______________