NATIONAL CANNABINOID CLINICS

DOCTOR REFERRAL FORM

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

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?

☐ Chronic Pain
☐ PTSD
☐ Multiple Sclerosis
☐ Fibromyalgia
☐ Crohn's Disease
☐ CINV (Chemotherapy Induced Nausea and Vomiting)
☐ Seizures
☐ Insomnia
☐ Anxiety
☐ Arthritis
☐ Other. Please Specify: _____

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

_____

_____

_____

Reason forreferral: _____

_____

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: _____

Phone:_____ Fax: _____

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) _____