NATIONAL CANNABINOID CLINICS

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
☐ Part Time Employed
☐ Self Employed
☐ Part Time Student
☐ Unemployed
☐ Retired
☐ Full Time Student
☐ Other

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

This is a list of potential contraindications; please tick the ones you have a history of or are currently experiencing:

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

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 last consultation: _____

Practitioner name:_____ Specialty: _____

Phone: _____

Practice Address: _____

Approximate date of last consultation: _____

Practitioner name:_____ Specialty: _____

Phone: _____

Practice Address: _____

Approximate date of last consultation: _____

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By submitting this form:

- ☐ Accept NCC terms and conditions.
- ☐ Agree to allow National Cannabinoid Clinic to access your medical history records if needed.
- ☐ 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

Patient Full Name: _____

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: _____