AUSTRALIAN ACCESS CLINICS

Referral for Medical Cannabis Assessment

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Patient Details

FIRST AND LAST NAME | DOB (DD/MM/YY) | MEDICARE NUMBER

PHONE NUMBER | EMAIL ADDRESS

ADDRESS

Health Details

Symptom to be treated with medical cannabis

Primary diagnosis/condition causing symptom

Current medications treating symptom	Past medications trialled for symptom

Referring Doctor's Stamp/Details

DOCTOR'S SIGNATURE

DATE

☐ The patient has exhausted all registered/conventional options for the indication above.

☐ I have attached the **Patient's Health Summary (Required)** including past and current medical history, past and current medications trialled for above symptom and a list of treating physicians.

Please provide completed referral form to patient.
Patients can book an appointment online at www.acclinics.com.au.