



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.ausaccessclinics.com.au.