Cannahealth
Promoting better understanding.

DOCTOR REFERRAL FORM

PATIENT DETAILS

Full Name: ____________________

DOB: ____________________

Phone: ____________________

Email: ____________________

Address: ____________________

PRACTITIONER DETAILS

Practice Stamp: ____________________

Full name: ____________________

Phone: ____________________

Health Practitioner Type: ____________________

Provider Number: ____________________

Practice Address: ____________________

REFERRAL DETAILS

Indication / Symptom to be treated with Medicinal Cannabis:

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Medical condition causing this symptom:

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Please tick all that apply:

- ☐ Concerns with Medicinal Cannabis use in this patient. -if ticked, please specify:

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- ☐ Patient has tried or is unable or us unwilling to use standard registered medications for this indication.

- ☐ I have included the Patient's Health Summary *(very helpful)*, including past and current medical history; current and past.

I hereby refer the above patient to doctor/specialist ____________________ *for medical review and ongoing management.*

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