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## CDA Clinics Referral Form

### PATIENT TO COMPLETE

Full Name		DOB (DD/MM/YYYY)	
Phone		Email	
Address			
Type of Consultation	<input type="checkbox"/> Telehealth (Phone Consult) <input type="checkbox"/> Varsity Lakes Clinic <input type="checkbox"/> Brisbane Clinic		

I, \_\_\_\_\_ Authorise my Doctor to send my Health Summary to CDA.  
(name)

### PRACTITIONER TO COMPLETE

Practitioner Stamp/Details

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Medical Condition/s

Patient Symptom/s

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Concerns with Medicinal Cannabis use in this patient. \*If ticked, please specify:

\_\_\_\_\_

I have included the patient's Health Summary (required) including current medications.

I hereby refer the above patient to a Doctor at CDA Clinics for medical review.

Practitioner Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_