Fax 02 9167 7191
Phone 1300 232 362
Email info@cdaclinics.com.au

CDACLINICS

CDA Clinics Referral Form

PATIENT TO COMPLETE

Full Name		DOB (DD/MM/YYYY)	
Phone		Email	
Address			
Type of Consultation	☐ Telehealth (Phone Consult) ☐ Varsity Lakes Clinic ☐ Brisbane Clinic ☐ Maroochydore Clinic		

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

PRACTITIONER TO COMPLETE

Practitioner Stamp/Details (required) – *must include doctor's name and provider number*

Primary diagnosis/ condition causing symptom | Patient Symptom/s

☐ 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:____/____/____

Please attach Health Summary and fax with this Referral to 02 9167 7191
www.CDAclinics.com.au