

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, _____ (name) authorise my doctor to send my Health Summary to CDA.

PRACTITIONER TO COMPLETE

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

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Primary diagnosis/condition causing symptom 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: ____/____/____

*Patients with serious mental health disorders may be requested to provide a Letter of Endorsement from their current psychiatrist for THC prescriptions. Referring doctors must advise if the patient suffers from any mental health disorders.