Specialist DVA Referral Form

PATIENT TO COMPLETE

Full Name			
Phone		DOB (DD/MM/YYYY)	
Address		Email	
		DVA #	

PRACTITIONER TO COMPLETE

Practitioner stamp/details and signature (required) – must include doctor's name and provider number

DVA ENDORSEMENT DETAILS

Dear DVA VAPAC,

This patient would likely clinically benefit from medicinal cannabis treatment.

As such, I have outsourced to the doctors of CDA Clinics, the prescribing and applying for medicinal cannabis from VAPAC. On mental health and suicide risk examination this patient is of low risk of substance use disorder and mental health complications.

I have advised the above-named patient of relevant precautions and contraindications whilst using medical cannabis (products containing THC are generally not appropriate for patients who): have a history of hypersensitivity to any cannabinoid or products use in manufacture (e.g. hemp seed oil), have severe and unstable cardio-pulmonary disease or risk factors for cardiovascular diseases, have a previous psychotic or concurrent active mood disorder, or are pregnant/ breastfeeding. The patient will have further education from CDA Clinics clinicians, and ongoing monitoring from CDA Clinics clinicians.

Primary Diagnosis:	Primary Symptoms:
Secondary Diagnosis:	Severity:

Medicinal cannabis therapy for the potential improvement in (select all that apply):

Primary Symptoms	Mobility	ADLs	Mood
Quality of life	Sleep	Other (please specify) -	