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			

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

PRACTITIONER TO COMPLETE

Practitioner stamp/details and signature (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: ____/____/____

*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.