THE CANNABIS CENTRE

The Cannabis Centre Referral Form

PATIENT TO COMPLETE

Full Name		DOB (DD/MM/YYYY)	
Phone		Email	
Address			
Type of Consultation	☐ Telehealth (Phone Consult) ☐ In-Person - QLD ☐ In-Person - NSW		

I, _____ Consent for TCC to obtain a Health Summary from my Doctor.
(name)

PRACTITIONER TO COMPLETE

Practitioner Stamp/Details

Medical Condition/s | 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 within The Cannabis Centre network for medical review.

Practitioner Signature: _____ Date: ___/___/____

Please attach the Health Summary and email both the Summary and Referral
to **medical@thecannabiscentre.com.au**