Fax 02 9167 7191
Phone 07 5689 3740
Email info@cdaclinics.com.au

CDA CLINICS

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		

I,_____ Consent for CDA 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 at CDA Clinics for medical review.

Practitioner Signature:_____ Date:____/____/____

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