PlantMed

PATIENT REFERRAL FORM

Dr John Teh | Dr Rohan Reddy | Dr Built Amporndanai
Dr Mat Cetin | Dr Rebecca Olivo | Dr Moira West
Dr Cornelius Van Dorp | Dr Nerissa Naidoo

Name:

Guardian Name:
(if applicable)

DOB:

Medicare #: position exp

Phone:

Phone 2:

Address:

Email:

- ◯ Medication or treatment failed to alleviate
- ◯ Side effects of treatment outweighs benefit of treatment
- ◯ Wasting conditions/chronic illness
- ◯ Epilepsy (adult and paediatrics)
- ◯ Neurological disorders
- ◯ CINV/Palliative care
- ◯ Chronic pain

Symptoms

Current medications / treatment

Past treatment adverse side effects

REFERRING DOCTOR'S DETAILS

Name:

Provider #:

Medical Practice:

Address:

Email:

Phone:

Fax:

◯ Thank you for seeing my patient in regards to a trial of medicinal cannabis to help relieve above symptoms

Referrals not on this template accepted, please attach additional information or health summary if required

Referrals to: Fax 07 3112 4344 OR via Email: info@plantmed.net.au
Address: 1/288 Newmarket Road Wilston Q 4051 | Ph: 07 3193 9280 | www.plantmed.net.au

Signature: ________________________________ Date: ____________________