

Name:

Guardian Name:   
(if applicable)

DOB:  Medicare #:  position  exp

Phone:  Phone 2:

Address:

Email:

- |  |  |
|--|--|
| <input type="radio"/> Medication or treatment failed to alleviate              | <input type="radio"/> Neurological disorders |
| <input type="radio"/> Side effects of treatment outweighs benefit of treatment | <input type="radio"/> CINV/Palliative care   |
| <input type="radio"/> Wasting conditions/chronic illness                       | <input type="radio"/> Chronic pain           |
| <input type="radio"/> Epilepsy (adult and paediatrics)                         |  |

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](mailto:info@plantmed.net.au)**

Address: 1/288 Newmarket Road Wilston Q 4051 | Ph: 07 3193 9280 | [www.plantmed.net.au](http://www.plantmed.net.au)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

