



DOCTOR REFERRAL FORM

PATIENT INFORMATION

FIRST NAME

MIDDLE NAME

LAST NAME

PHONE NUMBER:

DATE OF BIRTH

EMAIL

MAILING ADDRESS

<input type="text"/>				
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Telehealth required

Consent to doctor sharing
my health summary with
QUEST participating doctor

FULL NAME & SIGNATURE ABOVE

PRACTITIONER TO COMPLETE

PRACTICE STAMP / DETAILS

INDICATION / SYMPTOMS TO BE TREATED WITH MEDICAL CANNABIS:

MEDICAL CONDITION CAUSING SYMPTOM:

PLEASE CHECK ALL THAT APPLY AND SPECIFY DETAILS

Concerns with medical cannabis in this patient.

Patient has tried or is unable or unwilling to use
standard registered medications for this indication.

I have included the patient's health summary
including past and current medical history as well
as current and past medications. **(required)**

I REFER THE ABOVE PATIENT TO A QUEST PARTICIPATING DOCTOR FOR MEDICAL REVIEW AND ONGOING MANAGEMENT OF MEDICAL CANNABIS:

SIGNATURE

DATE

Please return this form to your patient via email or printout so they can take this to a QUEST registered doctor.
The QUEST doctor directory can be found at: <https://www.thequestinitiative.com/book-a-doctor/>