DOCTOR REFERRAL FORM

PATIENT INFORMATION

FIRST NAME | MIDDLE NAME | LAST NAME

PHONE NUMBER: | DATE OF BIRTH

EMAIL

MAILING ADDRESS

☐ 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. QUEST doctors can be booked by calling 1300 664 369 or via https://www.thequestinitiative.com