# Patient Referral Form

**Patient Name**: _____

**Street Address:** _____

**Suburb/State/Postal Code:**_____

**D.O.B (dd/mm/yyyy):** _____

**Medicare Number:** _____

**Telephone:** _____

**Email:** _____

OR AFFIX PATIENT LABEL

**Patient Diagnosis:** _____

***Goals of Treatment:***

*If prescribing, we recommend speaking to this patient's other treating physicians regarding your intention to prescribe medicinal cannabis*

**Potential Contraindications**

□ Severe depression, anxiety, psychosis
□ Unstable CVD (angina, arrhythmias)
□ Pregnancy, planning pregnancy or breastfeeding
□ Family Hx of mental illness
□ Active substance use disorder
□ Opioid dependence treatment
□ Other:

***Please attach all current medications (incl. dose and frequency), and any past medications trialled for the above indication***

_____

_____

_____

_____

**Physician or ADMIN Email (Required for patient notifications)**:

□ I would like to prescribe medicinal cannabis for my patient
□ I do not want to prescribe and would like to refer this patient to a Tetra physician for an appointment

**Practice Stamp**

_____ _____

**Physician Signature** **Date (dd/mm/yyyy)**

**PLEASE FAX REFERRAL to +61 (0) 2 8079 0656 or email physicians@tetrahealth.com.au**

p: 1800 861 099 | www.tetrahealth.com.au