tetra health

p +1800 861 099 **f** +61 2 8079 0656
e physicians@tetrahealth.com.au
w tetrahealth.com.au

Patient Referral Form

Patient Name:

Street Address:

DOB [dd/mm/yyyy]

Telephone:

Medicare: Exp:

Email Address:

OR AFFIX PATIENT LABEL

Diagnosis:

Goals of Treatment:

If prescribing, we recommend communicating 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
- ☐ Cannabis use disorder
- ☐ Hepatitis C/Liver dysfunction
- ☐ Other:

Please attach health summary or list current medications and past medications trialled for the above indication

☐ *I would like to prescribe medical cannabis for my patient*

☐ *I do not want to prescribe, and would like to refer my patient to a Tetra Physician*

Physician or admin email (for patient reports):

Physician Signature

Date [dd/mm/yyyy]

Practice Stamp

Fax this referral to +61 (0) 2 8079 0656 or Email physicians@tetrahealth.com.au