CBD CLINICS AUSTRALIA

New Patient Referral Form

Name:

Guardian Name: (if applicable)

DOB: **Contact Number:**

Address:

Email:

Medicare Number: **IRN:** **Expiry:** ____/____

- ☐ Insomnia/Sleep Disorders
- ☐ Multiple Sclerosis
- ☐ Chronic Illness
- ☐ Epilepsy (adult and paediatrics)
- ☐ Adverse side effects from previously attempted therapies
- ☐ Chronic Pain Management
- ☐ Neurological Disorders
- ☐ Palliative Care
- ☐ Anxiety Disorder
- ☐ Insufficient symptom relief with conventional therapies

Symptoms:

Current medications / treatment:

Past treatment adverse side effects:

Referring Medical Practitioner Details

Name: **Prescriber #:**

Medical Practice: **Phone:**

Email:

Thank you for seeing my patient regarding a trial of integrative healthcare to help relieve the above symptoms. I have attached any further relevant information and/or health summary.

Signature: **Date:**

Please sent referrals to: contact@cbdclinicsaustralia.com.au or during patient registration

1800 961 982 | cbdclinicsaustralia.com.au