Chronic DOCTORS

REFERRAL FORM
CHRONIC DOCTORS

I _____ Authorize my doctor to send my health summary to Chronic Doctors.
name

PATIENT DEMOGRAPHICS

Full Name	
Phone	
Date of birth (DD/MM/YYYY)	
Address	
Email Address	

PATIENT DETAILS

Primary Diagnosis	
Patient Symptoms	
Concerns with Medicinal Cannabis use in this patient?	

PRACTIC DETAILS

Practice Name	
Address	
Phone number	
Fax number	
Email	

DOCTOR DETAILS

Doctor Stamp (including name and Medicare provider number)	

I hereby refer the above patient to a Doctor at Chronic Doctors for medical review

Please include an up-to-date health summary of current and past medical history.

Practitioner signature _____ **Date** ____/____/____