



DR ANUPAM CHAUHAN

# 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 Dr Anupam Chauhan.

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.

Results of any scans. (if available)

1-2 relevant reports from specialist previously seen. (if available)

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 the appointment with Dr Chauhan.

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