EMC CLINIC

ANNUAL REFERRAL

PATIENT TO COMPLETE

Full name	
DOB (DD-MM-YYYY)	
Address	
Phone	
Email	

I, the patient or legal carer, authorise my doctor to send my Health Summary to Australani Clinic, and Australani to request and receive further medical information about me. I additionally consent to the Policies, Terms & Conditions, and General Treatment Consent displayed on EMCClinic.com.au.

Patient/Carers Signature: _____ Date: / /

MEDICAL PRACTITIONER COMPLETE OR STAMP

Practitioner name	
Provider number	
Practice name	

Diagnosis of Referral to the Endocannabinoid Medicine Clinic:

Please attach the patient's Health Summary including current medications.

Additional Notes - Past Medical History, Medications, Allergies, Investigations, etc:

Practitioner Signature: _____ Date: / /

NOTE 1: Patients – please be advised Australani may request further information as required.

NOTE 2: Referring medical practitioner please advise if the patient suffers from any cognitive impairment or mental health disorder.