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 EMC Clinic, and EMC Clinic 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: / /

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## MEDICAL PRACTITIONER TO COMPLETE

| | |
|---|---|
| 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 EMC Clinic 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.