rise DISPENSARY

Shop 8 & 9 / 82 City Road,
Beenleigh QLD 4207
Phone: 07 3059 1301
Fax: 07 3112 4120
Email: hello@risedispensary.com.au

PATIENT'S DETAILS

Given name(s)

Surname

Date of birth

Phone

PATIENT REFERRAL FORM

- I have been seeing the patient as usual practitioner for at least the past 3 months. ☐
- I have access to enough PAST MEDICAL HISTORY to support this referral. ☐
- Health Summary (Active Medical Conditions / PMH / Current Medications / Allergies) attached: **REQUIRED** ☐
- Other available conventional treatment options been used previously. ☐
- Previous treatment outcomes: ☐ Suboptimal results ☐ Adverse-effects

QUALIFYING MEDICAL CONDITION/S:

ESTABLISHED DIAGNOSIS (supported by available relevant investigations / specialist reports)

Alzheimer's Disease ☐	Crohn's Disease ☐	Neuropathic Pain ☐
Anorexia ☐	Dementia ☐	Osteoarthritis ☐
Anxiety ☐	Depression ☐	Palliative Care ☐
ADHD ☐	Endometriosis ☐	Parkinson's Disease ☐
ASD ☐	Epilepsy ☐	PTSD ☐
Cachexia ☐	Inflammatory Bowel Disease (IBD) ☐	Seizure Management ☐
Cancer Symptom Management ☐	Insomnia ☐	Sleep Disorder ☐
Cancer-related Pain ☐	Irritable Bowel Syndrome (IBS) ☐	Spasticity ☐
Chemotherapy-Induced Nausea/Vomiting ☐	Mood Disorder ☐	Spasticity-associated Pain ☐
Chronic Non-cancer Pain ☐	Multiple Sclerosis (MS) ☐	

WARNING SIGNS

CURRENT or HISTORY OF

- Suicide Attempt/s ☐
- Suicidal Ideas / Intents ☐
- Drug Dependence / Substance Abuse ☐
- Severe COPD / Asthma ☐

CONTRAINDICATIONS

CURRENT or HISTORY OF	CURRENT
Schizophrenia ☐	Unstable Cardiovascular Disease ☐
Acute Psychosis ☐	Angina Pectoris ☐
Unstable Severe Bipolar ☐	Pregnancy / Breast Feeding ☐
Myocardial Infarction ☐	Plans For Imminent Pregnancy ☐

Please do not refer any patients if a box in the **BLACK (Contraindications)** section has been ticked.

SYMPTOMS MANAGEMENT STRATEGIES SO FAR

Non-opioid Analgesics ☐	Surgical Intervention/s ☐	Nerve Pain Agents ☐	Sleeping Agents ☐
NSAIDs ☐	US-Guided Injection/s ☐	Anti-depressants ☐	Psychotherapy / CBT ☐
Opioid Analgesics ☐	CT-Guided Injection/s ☐	Anxiolytics ☐	Others ☐

SPECIALIST/S INVOLVED

Orthopaedic / Spinal Surgeon ☐	Neurologist ☐	Psychiatrist ☐	Sleep Physician ☐
Pain Specialist ☐	Oncologist ☐	Gastroenterologist ☐	Gynaecologist ☐

ALLIED HEALTH PROVIDERS INVOLVED

Physiotherapist ☐	Exercise Physiologist ☐	Podiatrist ☐	Pyschologist ☐
Chiropractor ☐	Occupational Therapist ☐	Dietician ☐	Others ☐

Patient currently / has been previously using Cannabis: ☐ Yes ☐ No

Please attach a copy of the patient's Health Summary **REQUIRED** ☐

Referring doctor name / signature: _____

Referral Date:

STAMP