rise DISPENSARY

Beenleigh Clinic
Shop 8 & 9 / 82 City Road, QLD 4207

Holland Park Clinic
934 Logan Road, QLD 4121

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