

PLEASE FAX THIS FORM TO: 02 9475 5158

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## Specialist DVA Referral Form

### Patient Details

Full Name: \_\_\_\_\_ DOB (DD/MM/YY): \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_  
Address: \_\_\_\_\_  
Medicare Number: \_\_\_\_\_  
Condition/Diagnosis \_\_\_\_\_

### Practitioner Details

Practice Stamp:

-----OR-----

Full Name: \_\_\_\_\_ Health Practitioner Type: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_  
Principal Practice Address: \_\_\_\_\_  
Provider Number: \_\_\_\_\_  
**Speciality:** \_\_\_\_\_

### DVA support Details

Please Tick all:

- Medicinal cannabis would clinically benefit the above named patient's condition.
- I have advised the above named patient of potential contraindications (products containing THC are generally not appropriate for patients who:
  - Have a history of hypersensitivity to any cannabinoid or products used in manufacture (e.g. sesame oil);
  - Have severe and unstable cardio-pulmonary disease (angina, peripheral vascular disease, cerebrovascular disease and arrhythmias) or risk factors for cardiovascular diseases
  - Have a previous psychotic or concurrent active mood disorder or anxiety disorder
  - Are pregnant/breastfeeding—there are some reports of pre-term labour and low birth weight. Cannabinoids appear in the breast milk.
- I have undertaken a suicide and mental health assessment and determined there is no increased risk from medicinal cannabis on suicide ideation or mental health and the patient has no current substance use disorder/has low risk for substance use disorder.

Practitioner Signature: \_\_\_\_\_ Date (DD/MM/YYYY): \_\_\_\_\_

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Please contact [info@caclinics.com.au](mailto:info@caclinics.com.au) or [1300 991 477](tel:1300991477) for all enquiries

[www.cannabisaccessclinics.com.au](http://www.cannabisaccessclinics.com.au)