

DVA Specialist Support Form

! Patient Details

Full Name: DOB (DD/MM/YY): / /

Phone Number: Email:

Address: Medicare Number:

Dva File No.: Card type: ☐ Gold ☐ White ☐ Orange

! Practitioner Stamp/Practitioner Details

! DVA Support Details

I confirm that : I am not the prescribing doctor for the above named patient's medicinal cannabis medication. I am referring the below requested written assessment points to their doctor at CA Clinics.

1. A suicide and mental health assessment has been undertaken and documented, determining there is no increased risk from medicinal cannabis on suicide ideation or mental health.
2. The patient has no current substance use disorder and has low risk for substance use disorder.
3. Medicinal cannabis would clinically benefit the above named patient's condition.
4. The patient has been advised of potential contraindications

Practitioner Signature: Date (DD/MM/YY):

**Please attach health summary/medical history
and fax this form to: 02 9475 5158**

PRINT**RESET**