MEDICAL CANNABIS REFERRAL FORM

To be filled in by the referring doctor

Patient Details:

Name and surname……………………………………………..………………………

I.D. card number:……………...……… Date of birth:……………Age:………………..

Mobile number :………………….……Email address:…………..……………………...

Medical Condition(s):……………………………………………………………………

Is there diagnostic evidence of the chronic condition, e.g. X-ray, MRI, blood tests? Yes/No

Reason(s) for requesting medical cannabis:…………………………………….….…

Has the patient ever been seen by a psychiatrist? Yes/No

If yes, give details………………………………………………………….……….

Medications tried in the past:

1. ………………… Dose………… Frequency……. Side effects………………………..
2. ………………… Dose………… Frequency……. Side effects………………………..
3. ………………… Dose………… Frequency……. Side effects………………………..
4. ………………… Dose………… Frequency……. Side effects………………………..
5. ………………… Dose………… Frequency……. Side effects………………………..
6. ………………… Dose………… Frequency……. Side effects………………………..
7. ………………… Dose………… Frequency……. Side effects………………………..
8. ………………… Dose………… Frequency……. Side effects……………………….

Does the patient have a driving license? Yes/No

Does the patient have a history of heart disease or respiratory disease? Yes/No

If yes, give details…………………………………………………………….

………………………………………………………………………………..

Does the patient have a family history of schizophrenia or psychosis? Yes/No

Is the patient pregnant, breastfeeding or planning a baby? Yes/No

Does the patient have a clean criminal record? Yes/No

Has the patient ever used cannabis/CBD before? Yes/No

If yes, give details…………………………………………………………….

………………………………………………………………………………..

Is the patient under the care of any other consultant? Yes/No

If yes, did they consent to the patient's use of medical cannabis? Yes/No

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<u>To be filled in by the patient</u>

I, ………………………………………….., holder of I.D ………………… hereby declare that I take full responsibility of my use of this medicine. I am aware that if I smoke, sell, share, drive under the influence or abuse the medicine in any way, I could be liable to criminal charges. I have no objection if my information is used anonymously for research purposes.

……………………………….	……………………………………
Patient's signature	Doctor's signature
………………………………..	……………………………………
Date	Doctor's Name and Registration No.