MEDICAL CANNABIS REFERRAL FORM

To be filled in by the patient/referring professional

Name and Surname…….

I.D. card number:……. Date of birth:……

Age:…….. Telephone:……. Mobile:……

Address:……

Medical Condition(s):……..

Do you have evidence of your condition, e.g. X-ray, MRI, blood tests? Yes/No

Reason(s) for requesting medical cannabis:……

Have you 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…….

Do you have a driving license? Yes/No

Do you have a history of heart disease or respiratory disease? Yes/No

If yes, give details…….

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Do you have a family history of schizophrenia or psychosis? Yes/No

Are you pregnant, breastfeeding or planning a baby? Yes/No

Do you have a clean criminal record? Yes/No

Have you ever used cannabis/CBD before? Yes/No

If yes, give details…….

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Are you under the care of any other consultant? Yes/No

If yes, did you get consent from them? Yes/No

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.

……	…….
Patient's signature	Doctor's signature
……..	……
Date	Witness to signatures