IvyMed Clinic Referral Form

Patient to complete

Name: _____

Date of birth: _____

Address: _____

Telephone: _____

I, _____ authorise my doctor to send my health summary to IvyMed Clinic.

Practitioner to complete

Practitioner name and provider number: _____

Primary diagnosis / condition causing symptoms: _____

_____

_____

_____

☐ Concerns with medicinal cannabis use in this patient * if ticked, please specify:

_____

_____

☐ I have included the patient's health summary including current medications.

I refer the above patient to a doctor at IvyMed Clinic for medical review.

Practitioner signature: _____ Date: _____

Please send the referral and health summary, including any relevant specialist letters or investigations, using the following options:

- **Upload to Healthlink using our Practice ID: ivymedcl;**
- **Fax: NSW 02 8365 4941, SA 08 7223 2069, VIC 03 9959 8331;**
- **Email: info@ivymedclinic.com.au.**

Thank you.