MEDI-GREEN

Patient Contact Information

Name : _____

Gender : _____

Address : _____

City/Province/Postal Code : _____

Date of Birth : _____

Telephone Number : _____

E-Mail Address : _____

Skype Username : _____

Primary Diagnosis : _____

Secondary Diagnosis : _____

Licensed Producer : _____

Patient consent to disclose personal health information (PHI) form

Patient Name: _____ D.O. B: _____
Phone Number: _____ Email: _____
Address: _____

I_____, consent the release of personal health information (PHI) by way of unsecured email. I recognize that other options have been made available to me by way of secure fax directly to the office.
Initial_____

I_____, understand that sending personal health information through unsecure email is not necessarily at a high risk of diversion, but this risk is considerably lowered when sending personal health information by way of secure fax
Initial_____

I_____, give authorization to share my personal health information with the physician/nurse practitioners' clinic to which I wish to have an assessment.
Initial_____

I_____, understand the purpose for disclosing this personal health information and I understand that I can refuse to sign this form.
Initial_____

I hereby release the assessing physician, nurse practitioner, his/her clinic, my family physician and any other involved physician from any and all actions, claims, causes of actions, complaints (even by family and friends) and demands for damages, loss, or injury whatsoever arising directly or indirectly as a consequence to my use of medical cannabis and my application to possess medical cannabis

Signature:_____Date: _____

Witness:_____Date: _____

TREATMENT AGREEMENT AMONG PHYSICIAN/NURSE PRACTITIONER AND PATIENT
FOR PATIENTS PURSUING MEDICAL CANNABIS DOCUMENT

I,_____, understand that this Release and Acknowledgement contains important information about medical cannabis the assessing physician/nurse practitioner requires that I acknowledge and understand before he/she may issue a prescription and/or authorization for use of medical cannabis.

I further understand that the consulting physician/nurse practitioner will not necessarily be assuming care for me. He/she will however, assess and evaluate the appropriateness of my request to use medical cannabis to assist in treating the conditions and associated symptoms that I believe; from my own personal experience and research, medical cannabis to be helpful in treating.

I therefore confirm that the assessing physician/nurse practitioner will be my medical practitioner for the sole purpose of medical cannabis authorization and/or prescriptions.

I agree not to make any claim or commence any legal proceeding against the assessing physician/nurse practitioner, his/her practice, my family physician or any other involved physicians (such as specialists) in relation to:
a) my use of cannabis as a medicine; and
b) my application, or prescription for possessing, obtaining and using medical cannabis.

I understand physician/nurse practitioners generally agree that medical cannabis:

- May distort perception (sight, sounds, touch, time)
- May impair memory and learning
- May impair coordination (avoid driving 4 hours after inhaling and 8 hours after ingesting)
- May impair thinking and problem-solving
- May increase heart-rate and reduce blood pressure
- May increase anxiety, fear, distrust or panic

I am aware there is considerable debate and a great lack of consensus among physician/nurse practitioners about:

- The appropriate medical use of cannabis
- The appropriate dosage for medical cannabis
- The risks of smoking cannabis as compared to vaporizing or ingesting medical cannabis
- The risks of smoking the whole plant medical cannabis as compared to extracting the medicinally active cannabinoids and medicating with the same
- The long-term health and psychological risks associated with the use of medical cannabis
- The degree to which regular consumption of the medical cannabis:
  a) may contribute to pulmonary infections and respiratory cancer
  b) may damage the cells in the bronchial passages which protect the body against inhaled microorganisms and decrease the ability of the immune cells in lungs to fight fungi, bacteria, and tumor cells. For patients with already weakened immune systems, this means an increased in the possibility of dangerous pulmonary infections, including pneumonia
  c) May weaken various natural immune mechanisms, including macrophages and T-Cells
  d) May correlate in some cases with mental illness, such as bipolar disorder and schizophrenia

I am further aware that the above listed medical conditions are further compounded by the lack of consistency and uniformity in available medical cannabis products. With conventional drug products, I generally consume a medication as a precisely known molecular quantity. I recognize that raw plant medical cannabis does not work this way. I appreciate that I will get varying compositions of different cannabinoids and varying proportions of different cannabinoids from strain of plant to strain of plant and even, to a lesser degree, from plant to plant of the same strain.

I further appreciate that there is a significant uncertainty regarding the consistency of the medical cannabis drug product may medicate with which further complicates and compounds the practical issue of medicating with an inconsistent drug product like medical cannabis.

I am further aware that ingesting a high dose of medical cannabis can cause nausea and disorientation. Despite all these medical concerns debates and practical issues, I honestly believe that for the treatment of my conditions and symptoms, the benefits of medicating with medical cannabis outweigh the risks.

I agree to receive a medical document (prescription) for medical marijuana only from one physician/nurse practitioner. I also agree if purchasing medical cannabis, I will do so from a Licensed Producer otherwise, I will apply to Heath Canada for a Production License – Personal or Designated Grower.

I agree to safely store my medical cannabis so that no other person may access it either deliberately or accidentally. I am aware that young people (under 25 years) may experience psychosis after consuming medical cannabis and will ensure no child or young person will be exposed to my medical cannabis either directly or indirectly. I will contact Poison Control immediately if any child gains access to my supply of medical cannabis.

I am aware that taking medical cannabis with other substances, especially sedating substances may cause harm and possibly even death. I will not use illegal drugs (cocaine, heroin etc.) or controlled substances (narcotics, stimulants etc.) that were not prescribed for me.

I will inform the physician/nurse practitioner of all controlled substances that are prescribed to me by my regular physician.

I agree to have a medical assessment performed by my regular physician every 12 months.

I am aware that medical cannabis use is not advisable during pregnancy and breastfeeding. I agree to inform my physician/nurse practitioner if I am pregnant. If I become pregnant while being treated with medical cannabis, I will immediately stop using it until I have consulted with a physician.

This is my decision and I also do not support any claims made by my family, friends or other interested parties against said clinic and physician/nurse practitioners.

I hereby release the assessing physician/nurse practitioner, his/her clinic, my family physician, and any other involved physicians from any and all actions, claims, causes of actions, complaints (even by my family and friends) and demands for damages, loss or injury whatsoever arising directly or indirectly as a consequence to my medical cannabis and my application to possess medical cannabis.

This release from liability is to be binding on heirs, executors and assigns. I also consent to the disclosure, sharing and use of my personal information and medical data by the assessing physician, his/her clinic and my licensed commercial producer.

I understand and acknowledge that while the assessing physician/nurse practitioner may execute a declaration that I stand to potentially benefit from medical cannabis, the assessing physician/nurse practitioner will not serve as my primary care physician/nurse practitioner. As such I agree to seek regular medical care from my primary care physician and that the assessing physician/nurse practitioner will only deal with assessing his support for my medical cannabis use.

If licensed, I agree not to resell or give away any of my medication. I agree to check with local bylaws in my area.

Patient Name: _____ Witness Name: _____

Patient Signature: _____ Witness Signature: _____

Date Signed: _____ Date Signed: _____
Month Day Year Month Day Year

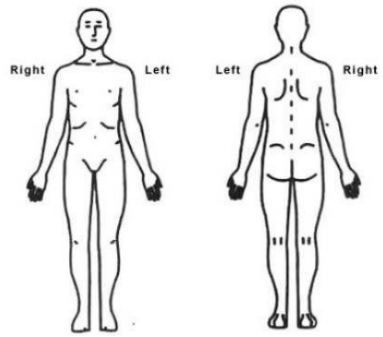
Brief Pain Inventory

Name:_____
Date:_____ **Time:**_____

1. Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains and toothaches). Have you had pain other than these everyday kinds of pain today?

Yes No

2. On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



3. Please rate your pain by circling the one number that best describes your pain at its **worst** in the past 24 hours.

0 1 2 3 4 5 6 7 8 9 10

No Pain *Pain as bad as you can imagine*

4. Please rate your pain by circling the one number that best describes your pain at its **least** in the last 24 hours.

0 1 2 3 4 5 6 7 8 9 10

No Pain *Pain as bad as you can imagine*

5. Please rate your pain by circling the one number that best describes your pain on **average**.

0 1 2 3 4 5 6 7 8 9 10

No Pain *Pain as bad as you can imagine*

6. Please rate your pain by circling the one number that best describes how much pain you have **right now**.

0 1 2 3 4 5 6 7 8 9 10

No Pain *Pain as bad as you can imagine*

8. In the past 24 hours, how much relief have pain treatments or medications provided? Please circle the one percentage that most shows how much relief you have received.

0% 10 20 30 40 50 60 70 80 90 100%

No Relief *Complete Relief*

9. Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

a) General Activity

0 1 2 3 4 5 6 7 8 9 10

Not at all *Greatly Interferes*

b) Mood

0 1 2 3 4 5 6 7 8 9 10

Not at all *Greatly Interferes*

c) Walking ability

0 1 2 3 4 5 6 7 8 9 10

Not at all *Greatly Interferes*

d) Normal Work (includes both work outside/home/housework)

0 1 2 3 4 5 6 7 8 9 10

Not at all *Greatly Interferes*

e) Relations with other people

0 1 2 3 4 5 6 7 8 9 10

Not at all *Greatly Interferes*

f) Sleep

0 1 2 3 4 5 6 7 8 9 10

Not at all *Greatly Interferes*

g) Enjoyment of life

0 1 2 3 4 5 6 7 8 9 10

Not at all *Greatly Interferes*

h) Ability to concentrate

0 1 2 3 4 5 6 7 8 9 10

Not at all *Greatly Interferes*

i) Appetite

0 1 2 3 4 5 6 7 8 9 10

Not at all *Greatly Interferes*

10. In the area where you have pain, do you have "pins and needles", tingling or prickling sensations?

Yes *No*

11. Does the painful area change colour (perhaps mottled or red) when the pain is particularly bad?

Yes *No*

12. Does your pain make the affected skin abnormally sensitive to the touch?

Yes *No*

13. Does your pain come on suddenly and in bursts for no apparent reason when you are completely still?

Yes *No*

14. In the area where you have pain, does your skin feel unusually hot like burning pain?

Yes *No*

15. Gently ***rub*** the painful area with your index finger and then rub a non-painful area. How does the rubbing feel in the painful area?

☐ No difference
☐ Discomfort – pins and needles, tingling or burning in the painful area

16. Gently ***press*** on the painful area with your fingertip then gently press in the same way to a non painful area. How does this feel in the painful area?

☐ No difference
☐ Discomfort – pins and needles, tingling or burning in the painful area

Modified from McCaffery M, Pasero C: Pain: Clinical manual, p 61, 1999, Mosby, Inc. From Pain Research Group, Department of Neurology, University of Wisconsin-Madison. Bennett MI 2001 PAIN 92:147-157

HADS (Hospital Anxiety & Depression Scale)

Please read each statement below and circle the number which best describes how true the feeling is for you.

	Yes, Definitely	Yes, Sometimes	No, Not Much	No, Not At All
1. I wake early and then sleep badly for the rest of the night.	3	2	1	0
2. I get very frightened or have panicked feelings for apparently no reason at all.	3	2	1	0
3. I feel miserable and sad.	3	2	1	0
4. I feel anxious when I go out of the house on my own.	3	2	1	0
5. I have lost interest in things.	3	2	1	0
6. I get palpitations, or sensations of “butterflies” in my stomach or chest.	3	2	1	0
7. I have a good appetite.	0	1	2	3
8. I feel scared or frightened.	3	2	1	0
9. I feel life is not worth living.	3	2	1	0
10. I still enjoy the things I used to.	0	1	2	3
11. I am restless and can't keep still.	3	2	1	0
12. I am more irritable than usual.	3	2	1	0
13. I feel as if I have slowed down.	3	2	1	0
14. Worrying thoughts constantly go through my mind.	3	2	1	0

Source: Ziqmond AS et al. Acta Psychiatrica Scandinavica 1983; 67: 361-370

Opioid Risk Tool Clinician Form

(includes point values to determine scoring total)

Mark each box that applies.

	Female	Male
1. Family History of Substance Abuse:		
Alcohol	☐ 1	☐ 3
Illegal Drugs	☐ 2	☐ 3
Prescription Drugs	☐ 4	☐ 4
2. Personal History of Substance Abuse:		
Alcohol	☐ 3	☐ 3
Illegal Drugs	☐ 4	☐ 4
Prescription Drugs	☐ 5	☐ 5
3. Age (mark box if between 16-45)	☐ 1	☐ 1
4. History of Preadolescent Sexual Abuse	☐ 3	☐ 0
5. Psychological Disease:		
Attention Deficit Disorder, Obsessive-Compulsive Disorder, Bipolar, Schizophrenia	☐ 2	☐ 2
Depression	☐ 1	☐ 1
Scoring Totals:	_____	_____

Total Score Risk Category:

Low Risk: 1-3

Moderate Risk: 4-7

High Risk: ≥8

Name: Date:

Address: Doctor's Name:

City: Prov.: Referred by:

Telephone #: Occupation: D.O.B.:

Medical Cannabis Assessment

Chief Problem for Which Cannabis Is Being Requested: _____

What year did the problems start?_____(year)

What can you do **physically** that makes the symptoms worse?

What can you do **physically** to feel better? (if anything)

Are there any secondary medical problems? No Yes (circle one)

If Yes, please list the diagnoses:

Do you currently use marijuana for relief? No YES - smoke, vapour, edible?

If YES above, how many times a day do you use it? _____

When did you last use it?_____How long have you used it **medically**?_____

If Yes, do you obtain it non-legally from a street source? No Yes

If you do not obtain a prescription for marijuana, will you continue to use it? No Yes.

Do you smoke tobacco? No Yes - cigarettes, cigars, pipe- number per day._____

Do you drink alcohol? No Yes - beer, wine or spirits - how much per week? _____

Do you use medicines containing opiates? (Codeine, morphine, other) No Yes

If Yes, which ones do you use, how often and what dosage? _____

Do you use cocaine or other "street" drugs? No Yes If Yes, which ones do you use and how often? _____

Are you allergic to any medicine? No Yes

If Yes, please list the medications you are allergic to:

Family History:

Is your father alive? No. Yes. In good health? If "No" - cause of death

Is your mother alive? No. Yes. In good health? If "No" - cause of death

Do you have siblings? No. Yes. (Please list ages, genders and states of health)

Do any of your family members suffer from psychiatric disorders? No Yes.

Medications: (please list your current prescription medications, the doses and times taken)

(provide list printed at medical pharmacy)

Please list any medications that have **FAILED** to work for you:

Social history: single, married, divorced, other (please circle one).

Dwelling: house, apartment, shared space, institution, no fixed address (please circle one).

Who lives with you? (Wife, husband, partner, no one) (please circle one).

If children are in your dwelling, please list them and their ages:

History of Operations-Surgeries: (please list any surgery you have had and the year)

Psychological History: (please circle diagnosis below)

Do you suffer from: Anxiety Depression Insomnia Bipolar disorder OCD.

What year did the condition begin?_____.

Have you been hospitalized for any of these? No Yes (what year)_____.

Have you had any thoughts of self-harm or suicide? No Yes.

Review of Systems

Do you have any problems with senses (smell, taste, sight, hearing or touch)? No Yes.

Do you have any problems with your head or neck? No Yes.

Do you have any problems with breathing or lung diseases? No Yes.

Do you have heart or circulation problems? No Yes.

Do you have problems climbing stairs or exercising? No Yes.

Do you have any eating, swallowing, digestion or problems with bowels? No Yes.

Do you have any problems with your kidneys, bladder or urination? No Yes.

Pregnancy: are you pregnant now or might you become pregnant in the near future? No Yes.

Do you have problems with your muscles or joints? No Yes.

If yes, please indicate which joints or muscles are bothering you.

General: Height: Weight:

Are you in any distress now? No Yes.

If Yes, please describe.

Do you feel comfortable now? No Yes.

Are you aware of the date, time and current location? No Yes.

Are you often confused? No Yes.

If you drive a vehicle on the road or operate machinery, do NOT do so:

1. Within 4 (FOUR) hours of inhaling cannabis vapour or smoke,

2 Within 6 (SIX) hours of eating or ingesting cannabis edibles or oil,

3. Within 8 (EIGHT) hours of using, if you get euphoric or dizzy - "Stoned"

Remember to keep all cannabis products, and medicines, in a Locked Box.

Signature of patient: _____

Assess:

Plan: