GreenGoddess Canna-Health/Marijuana Access Canada
Cannabis Clinic
Pre-Evaluation Patient Information Questionnaire

Patient Information

Name

Date

How did you hear about us?

Are you a new Patient?

Yes

No

Date of Birth

Age

Height
Feet and Inches

Weight
Lbs

Gender

Male

Female

Address

City

Province

Postal Code

Home Phone

Work Phone

Cell Phone

Email

May we email you in the future?

Yes

No

Please indicate if you have submitted a photo ID with your application:

Yes
If yes, please explain:

Are you currently attending school?

Yes
if yes where?

No

Are you currently working?

Yes
(if yes) What is your job?

No

Marital Status:

Do you have children?
Yes
if yes what are their ages?

No

Are you currently pregnant?

Are you planning on getting pregnant?

Are you currently breast-feeding?

Do you currently have Medical insurance?

Yes
if yes please explain:

No

Have you been arrested or charged with a crime in the past two years?

Yes

If yes, please describe:

No

Patient Signature*

Date

Medical History

Have you been evaluated for medical marijuana use by another physician in the past?

Yes

If yes, please give name of practice, doctor, date seen and condition for evaluation:

No

Have you been denied a prescription for medical marijuana use by another MD in the past?

Yes

If yes, please explain:

No

Are you currently attending or have you attended any substance abuse or rehabilitation program?

Yes

If yes, please provide details:

No

Do you ever have thoughts of suicide or have you ever attempted suicide?

Yes

If yes, please provide details:

No

Please indicate what medical records you will be submitting with your application:

Do you have a primary care physician?

Yes

If yes, Name, Address, Phone:

No

Have you talked to your primary care physician about medical marijuana?

Yes

No

Current medical complaint(s):

Patient Signature*

Date

What prescription drugs do you take currently and what dosages:

Do you currently use tobacco?

Yes

If yes, how often?

No

Do you currently use marijuana?

Yes

(if yes) How often and what methods?

No

Do you currently drink alcohol?

Yes

(if yes) How often?

No

Do you currently use cocaine, methamphetamine, opiates, heroin or other street drugs?

Yes

If yes, explain:

Are you allergic to any medicine?

Yes

If yes, list medicine:

No

Have you ever been hospitalized?

Yes

if yes, please provide dates and details:

Have you ever had surgery?

Yes

if yes, please provide dates and details:

No

Are there any other health problems that occur frequently with you or your family?

Yes

No

Please select if any of the following problems anyone in your immediate family has:

Asthma

Stroke

High Blood Pressure

Cancer

Diabetes

Alcoholism

Hepatitis

Tuberculosis

Substance Abuse

Kidney Disease

Heart Disease

Sinusitis

Other

if others Specify:

Please select if any of the following problems you have:

Sleeplessness

Chest Pain

Constipation

Diarrhea

Loss of Appetite

Vomiting

Anxiety

Rectal Pain

Swollen Ankles

Skin Rash

Palpitations

Headaches Chronic Pain

Muscle Spasm

Difficult Swallowing

Fever

Heart Burn

Seizures

Eye Problems

Blood in Bowels

Other

if others Specify:

Patient Signature*

Date

Acknowledgements, Agreements, Disclosures and Informed Consent

Please read each item below and initial in the space provided to indicate that you understand and agree to each item.

By initialing, you understand and agree to the information disclosed.

If you have questions or do not understand the information below, consult with the attending physician before initializing or signing this agreement.

Please do not sign this agreement and do not use marijuana if you do not understand the information you have received.

Patient agrees by initialing the following:

I understand that medical marijuana is a medicine used in treating the suffering caused by serious and debilitating medical conditions. Serious and debilitating medical

conditions include: Cancer, HIV, Nausea, Arthritis, Chronic Pain, Glaucoma, Cachexia, Seizures and persistent muscle spasms. Additionally, medical marijuana is used in the treatment of other chronic or persistent medical symptoms that: Substantially limits the ability of the person to conduct one or more major life activities Other conditions for which marijuana provides relief If not alleviated, may cause harm to the patient's safety or physical or mental health.

I have been advised that the use of medical marijuana may affect my coordination, motor skills and cognition in ways that could impair my ability to drive and agree not to operate heavy machinery, drive or engage in potentially hazardous activities.

I understand that side effects may occur while I am taking medical marijuana. Side effects of medical marijuana can include but are not limited to: Euphoria, difficulty in completing complex tasks, low blood pressure, sedation, dysphoria, alterations in the perception of time and space, dizziness, anxiety, confusion, impairment to short term memory, inability to concentrate, suppression of the body's immune system, increased talkativeness, impairment of motor skills, delayed reaction time, loss of physical coordination, paranoia psychotic symptoms and overeating.

I understand that some patients become dependent on marijuana. This means they experience withdrawal symptoms when they stop using marijuana. Signs of withdrawal symptoms can include: Feelings of depression, sadness, irritability, insomnia, restlessness, agitation, loss of appetite, trouble concentrating, sleep disturbances and unusual tiredness.

I understand that chronic use of medical marijuana can lead to laryngitis, bronchitis and general apathy.

I understand that although marijuana does not produce a specific psychosis, other possibilities exist such as exacerbating schizophrenia in persons predisposed to that disorder.

I agree to tell the attending physician if I have ever had symptoms of depression, been psychotic, attempted suicide or had any other mental problems.

I also agree to tell the attending physician if I have ever been prescribed or taken medicine for any of the conditions stated above. Furthermore, I understand that the attending physician does not suggest nor condone that I cease treatment and or medication that stabilize my mental or physical condition.I understand there are few known interactions between marijuana and medications other than herbs. However, very few interactions between herbs and medications have been studied. I agree to tell my attending physician if I

am using any herbs, supplements or other medications.

I am aware that the Controlled Drugs and Substances Act (CDSA) prohibits possession, trafficking, import and export, and production of controlled substances, including marijuana, unless authorized by regulations. Neither the MMPR nor any other Health Canada regulations authorize licensed producers to provide marijuana for medical purposes through a storefront.

I am aware that dried marijuana is not an approved drug or medicine in Canada. The Government of Canada does not endorse the use of marijuana, but the courts have required reasonable access to a legal source of marijuana when authorized by a healthcare practitioner.

I understand that Under the Access to Cannabis as Medicine Program Regulations, an authorized healthcare practitioner includes physicians in all provinces and territories, and nurse practitioners in provinces and territories where supporting dried marijuana for medical purposes is permitted under their scope of practice.

I understand some users might develop a tolerance to marijuana. This means higher and higher doses are required to achieve the same benefit. It is recommended for patients to have an intermission with the drug for at least 3 weeks every 3-4 months. If I think I may be developing a tolerance to marijuana, I will notify the attending physician.

I understand the benefits and risks associated with the use of marijuana are not fully understood and that the use of marijuana may involve risks that have not been identified. I accept such risk.

I understand should respiratory problems or other ill effects be experienced in association with the use of medical marijuana, I agree to discontinue its use and report any such problems or effects to the attending physician. Although smoking marijuana has not been linked to lung cancer, smoking marijuana can cause respiratory harm, such as bronchitis. Many researchers agree that marijuana smoke contains known carcinogens (chemicals that can cause cancer) and that smoking marijuana may increase the risk of respiratory diseases and cancers in the lungs, mouth and tongue. I have been advised that medical marijuana smoke contain chemicals known as tars that may be harmful to my health.

I understand that there are many methods of intake that substantially reduce the harmful effects of smoking such as vaporizers, edibles, drops, etc.

I understand Marijuana varies in potency. The effects of marijuana can also vary with the delivery system. Estimating the proper marijuana dosage is very important. Symptoms of marijuana overdose include, but are not limited to nausea, vomiting, hacking cough, abnormal heart rhythms, numbness in the limbs, anxiety attacks and incapacitation.

If I start taking medical marijuana, I agree to tell my attending physician if I: Start to feel sad or have crying spells, lose interest in my normal activities, have changes in my normal sleeping patterns, become more irritable than usual, lose my appetite, become unusually tired, withdraw from family and friends, or any other side effect that is not to your liking.

I agree that if I am a female patient that I will contact my attending physician if I become or are thinking about becoming pregnant. I acknowledge that the use of medical marijuana creates pass-through problems to a fetus during pregnancy and to a baby during breastfeeding.

I understand that using marijuana while under the influence of alcohol is not recommended. Additional side effects may become present when using both alcohol and marijuana.

I should not be driving a vehicle while using marijuana and that I can get a DUI for driving under the influence.

I am aware that medical marijuana is not regulated by the Food and Drug Regulations. Studies supporting the safety and efficacy of cannabis for therapeutic purposes are limited and do not meet the standard required by the Food and Drug Regulations for marketed drugs in Canada, and therefore may contain unknown quantities of active ingredients, impurities and or contaminants.

I am not permitted to smoke within 1,000 feet of any daycare or school. If I reside near those institutions, I must use my medicine within the privacy of my own home.

I agree to follow up with the attending physician with supporting medical records pertaining to my medical conditions.

I understand the attending physician, staff and or representatives of Marijuana Access Canada are neither providing, dispensing nor encouraging me to obtain medical marijuana. I also acknowledge that the attending physician, staff and or representatives of Marijuana

Access Canada will NOT be providing or discussing information regarding dispensary, co-op, delivery service or any other way to obtain marijuana.

I certify that I have read this document and declare under penalty of perjury that the information contained herein it true, correct and complete. I acknowledge that any manipulation, alteration or falsification of this form, the prescription will result in the immediate termination of any legal right to my use of medical marijuana. Furthermore, Marijuana Access Canada will report any of the above mentioned activities to the appropriate local authorities.The physician, staff and representatives of Marijuana Access Canada are addressing specific aspects of my medical care and, unless otherwise stated, are in no way establishing themselves as my primary care physician/provider. Furthermore, the undersigned, my heirs, assigns, or anyone else acting on behalf, hold the physician and his/her principals, agents and employees, free of and harmless from any responsibility for any harm resulting to me and/or other individuals as a result of my medical marijuana use.

RELEASE OF LIABILITY

I attest that the information on this form is correct and any medical history presented or discussed with the doctor is all factual and complete to the best of my knowledge. I do not plan or intend to use my Physician's prescription for the purpose of illegally obtaining medical marijuana. Solely for verification purposes, I authorize to converse of my medical condition.

I understand that I must be a legal resident of Canada with a valid Canadian photo I.D.

I affirm that I have a serious medical condition that negatively affects my quality of life. I have found or am interested in finding out whether or not medical marijuana provides substantial relief and improvement in my condition.

I understand that the cannabis plant is not regulated by Food and Drug Regulations and therefore may contain unknown quantities of active ingredients, impurities and/or contaminants.

I understand the potential risks associated with an elevated daily consumption of medical marijuana including risks with respect to the effect on my cardiovascular and pulmonary systems and psychomotor performance, risks associated with the long-term use of marijuana, as well as potential drug dependency.

I am aware that the benefits and risks associated with the use of marijuana are not fully understood and that the use of marijuana may involve risks that have not been identified. In requesting an approval or recommendation for the use of medical marijuana, I assume full responsibility for any and all risks involved in this action.

I have been advised that medical marijuana smoke contains chemicals known as tars that may be harmful to my health. Recent research indicates that vaporizing cannabis may eliminate exposure to tar. Should respiratory problems or other ill effects be experienced in association with its use, it should be discontinued and reported to the physician immediately.

I was also advised that the use of medical marijuana may affect my coordination and cognition in ways that could impair my ability to drive, operate machinery, or engage in potentially hazardous activities. I assume full responsibility for any harm resulting to me and/or other individuals as a result of my use of cannabis.

I, the undersigned, hereby request a consultation by the physician for purposes of determining the appropriateness of medicinal marijuana treatment.

I acknowledge that using cannabis as a medicine has been explained to me and that any questions that I have asked have been answered to my complete satisfaction. The physician, staff, and representatives are addressing specific aspects of my medical care, and unless otherwise stated are in no way establishing themselves as my primary care provider. Should an approval be made for my medicinal use of marijuana, I understand that there is a renewal date specified by the physician depending on the condition. I understand that it is my responsibility to see the physician to assess the possible continuance of cannabis use beyond the term of the approval. Furthermore, the undersigned, or anyone acting on my behalf, hold the physician and his/her principals, agents, and employees, free of and harmless from any liability resulting from the use of medical marijuana.

I further understand that by signing below, I am authorizing the release of any part of this record, except for identifying information, for use in data analysis of medical marijuana treated patients.

Signature:

Date:

Medical Marijuana Patient Declaration

I hereby declare that I have completely and truthfully disclosed all information regarding my medical condition and attest that I do not intend to use my medical prescription for the purpose of illegally obtaining, growing or distributing medical marijuana.

I attest that I am not a member, employee or agent of any media or law enforcement agency. It is illegal to film or record in this office with a video camera, cell phone or any other recording devise be it a still image, video or audio. This is a direct violation of the Personal Health Information Protection Act (PHIPA) regulations and patient/doctor confidentiality. I am aware that my prescription can be revoked at any time and legal actions will be taken if I have perjured or misrepresented myself or my condition, my intentions or falsified any medical records to the physician. I also hereby authorize Marijuana Access Canada, or its representative to discuss my medical condition for verification purposes only.

Additionally, I acknowledge the attending physician informed me of the nature of a recommended treatment, including but not limited to, any recommendation regarding medical marijuana, the risks, complications and expected benefits of any recommended treatment, including its likelihood of success and failure. I acknowledge the attending physician informed me of any alternatives to the recommended treatment, including the alternative of no treatment, and their risks and benefits. The physician may request that I visit another physician or specialist to further substantiate my condition. I will be informed of all the above mentioned regardless of whether or not I qualify as a patient. The attending physician will fully explain to me the nature and purpose of medical marijuana treatment, including its benefits and possible side effects.

Signature*

Date

PHIPA Notice of Privacy Practices Acknowledgement of Receipt

By signing this, I hereby acknowledge that I have read and understand the privacy practice notice and may obtain additional copies upon my request. This acknowledgement will be filed with my records. Authorization for Release of Confidential Records I, hereby authorize Marijuana Access Canada to disclose and verify me as a patient to any law enforcement

agency, my physician(s), Child Protective Services or any marijuana dispensary/co-op. This is valid during the period of time for which the prescription has been issued. This consent is subject to written revocation only, at any time except to the extent that action has already been taken on the basis of this consent.

I give Marijuana Access Canada and the attending physician permission to validate my status as a patient using the Marijuana Access Canada online patient verification system.

I give permission for my medical records and file to be reviewed by another physician working with Marijuana Access Canada. I understand that this might happen if the original doctor that evaluated me requires a secondary opinion, is not available, off premise, has moved or terminated his/her practice.

Signature*

Date

DO NOT SIGN BELOW THIS LINE