Patient Assessment Form

Patient Assessment Form

For Patients Seeking a Medical Cannabis Document

General Details

First Name	
Last Name	
Lic. Producer	
Best Time to Reach You (eg After 5)	

D.O.B.	year	month	day
Gender	male ☐	female ☐	Current Age
If female, are you pregnant or nursing?	yes ☐	no ☐	
Heathcard #			

Contact Information

Address	
City	
Province/Postal C	

Home Phone	
Cell Phone	
Email	

General Practitioner Information

Name of Doctor	
Doctor's Address	
Doctor's City	
Province/Postal C	
Date of last visit	
Reason for last visit	

Are you seeing a Specialist?	yes ☐	no ☐	
Specialist Name			
Date of last visit			

Additional Notes

Patient Assessment Form

For Patients Seeking a Medical Cannabis Prescription

Your Medical Condition and Symptoms

Primary Condition	

Check off symptoms associated with your primary condition. Circle level of symptom severity. Level 1-not severe Level 5-very sever			
	Pain 1 2 3 4 5	Anxiety 1 2 3 4 5	Nausea/Vomiting 1 2 3 4 5
	Muscle Spasms 1 2 3 4 5	Depression 1 2 3 4 5	Low Energy 1 2 3 4 5
	Mobility 1 2 3 4 5	Concentration/Focus 1 2 3 4 5	Diarrhea 1 2 3 4 5
	headache 1 2 3 4 5	Sleep Disturbance 1 2 3 4 5	Constipation 1 2 3 4 5
	Seizures 1 2 3 4 5	Visual Disturbance 1 2 3 4 5	Medication Side Effects 1 2 3 4 5
	Involuntary Movements 1 2 3 4 5	Weight Loss 1 2 3 4 5	Other: _____ 1 2 3 4 5
		Lack of Appetite 1 2 3 4 5	_____ 1 2 3 4 5

Medical History

How much does your condition affect your daily routine? Circle level of symptom severity. Level 1-not severe Level 5-very severe	1 2 3 4 5 Comments:	How much does your condition affect your ability to work? Circle level of symptom severity. Level 1-not severe Level 5-very sever	1 2 3 4 5 Comments:
Current Medications: Please indicate the dosage	Medication: Medication: Medication:		
Drug Allergies			

What therapies have your tried? Check all that apply and circle level of effectiveness. Level 1-not effective Level 5-very effective			
	Physiotherapy 1 2 3 4 5	Current Prescription Medication _____ 1 2 3 4 5	
	Chiropractic 1 2 3 4 5	(Please also indication dosage) _____ 1 2 3 4 5	
	Naturopathic/Homeopathic 1 2 3 4 5	_____ 1 2 3 4 5	
	Counselling/Pyschotherapy 1 2 3 4 5	_____ 1 2 3 4 5	
	Therapeutic Injections 1 2 3 4 5	_____ 1 2 3 4 5	
	Acupuncture 1 2 3 4 5	_____ 1 2 3 4 5	
		_____ 1 2 3 4 5	

Have you been diagnosed with dependence on any drug, prescribed or otherwise?	☐y ☐n	Would you feel at risk using cannabis outside your current medical treatment?	☐y ☐n	Have you suffered from a Psychotic illness in the past or currently?	☐y ☐n	Have you previously used cannabis for symptom relief?	☐y ☐n	Have you ever been been prescribed synthetic cannabis?	☐y ☐n
Has a close family member suffered from Psychotic illness?	☐y ☐n	Do you suffer from heart disease?	☐y ☐n						

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Medical History Continued

The information you provide in this document is strictly confidential.

How much cannabis do you use per day?	☐ Less than 1g per day ☐ 1-2g per day ☐ 3-5g per day ☐ 6-10g per day		
What is your preferred method of taking cannabis?	Inhalation/Smoke ☐ Oral/Eat ☐ Topical/Cream ☐	What are your treatment goals?	Reduce pain ☐ Improve Daily Function ☐ Improve Appetite ☐ Improve Mood ☐ Improve Sleep ☐ Other _____
Why is cannabis appropriate as a medical treatment?			
How long have you been using cannabis?	☐ Less than 1 year ☐ 1-2 years ☐ 3-5 years ☐ 6-10 years ☐ 10-20 years ☐ 20-35 years ☐ 35+ years	Is cannabis your most effective medicine?	☐ Yes ☐ No
Has cannabis helped lower the dose of other prescription medications?	☐ Yes ☐ No		
If yes then which medication(s)?			
Have you ever experienced any negative side effects?	☐ Yes ☐ No		
If yes, please describe.			
Have you ever taken a break from cannabis?	☐ Yes ☐ No		
If yes, what happened?			

Signature			
Name			
Date Signed	month	day	year

Treatment Agreement between Doctor and Patient

For Patients Seeking a Medical Cannabis Document

I _____

I understand that this Release and Acknowledgement contains IMPORTANT information about medical cannabis that the assessing physician requires that I acknowledge and understand before he/she may issue a prescription and/or authorizaton for use of medical cannabis.

I further understand that the consulting physician 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 symtoms that I believe; from my own personal experience, medical cannabis to be helpful in treating.

I accordingly confirm that the assessing physician 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 proceedings against the assessing physician, his/her practice, my family physcician 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 am well aware that physicians generally agree that medical cannabis;

- May distort perception (sight, sounds, time, touch);
- May impair memory and learning
- May impair coordination (Avoid driving for 4 hours after smoking and 8 hours after injesting)
- May impair thinking and problem-solving
- May increase heart rate and reduces blood
- May produces anxiety, fear, distrust, or panic

I am well aware there is considerable debate and a great lack of consensus among physicians about:

- The appropriate medical use of cannabis
- The appropriate dosage for medical cannabis
- The risks of smoking medical cannabis as compared to vaporizing or ingesting medical cannabis
- The risks of smoking whole plant medical cannabis as compared to extracting the medicinally active cannabanoids and medicating with same;
- The long-term health and psychological risks associated with the use of medical cannabis
- The degree to which regular consumption of medical cannabis:

a) May contribute to pulmonary infections and respiratory cancer
b) May damage the cells in bronchial passages which protect the body against inhaled microorganisms and decrease the ability of the immune cells in the lungs to fight off fungi, bacteria, and tumor cells. For patients with already weakened immune systems, this means an increase in the possibility of dangerous pulmonary infections, including pneumonia
c) May weaken various natural immune mechanisms, including macrophages and T-cells
d) May corelate in some cases with mental illness, such as bipolar disorder and schizophrenia

I am further well aware that the above listed medical concerns are further compounded by the lack of consistency and uniformity in available medical cannabis products. With conventional drug products I generally consume a medication of 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 I 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.

In seeking medical cannabis treatment and I confirm I have consulted with a physician regarding alternative and conventional treatment options for my condition.

Initials

Treatment Agreement between Doctor and Patient

For Patients Seeking a Medical Cannabis Document

Despite all these medical concerns, debates and practical issues I honestly believe that for the treatment of my condition(s) and symptom(s) the benefits of medicating with medical cannabis outweigh the risks.

I agree to receive a “medical document” (ie prescription) for medical marijuana only from one physician.
I agree to purchase my marijuana only from a licensed producer. I am aware that possession of marijuana from other sources is illegal.

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

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

I will inform the doctor of all controlled substances that are prescribed to me by my regular doctor(s). I will inform my primary care physician that I am being prescribed medical marijuana. I agree to have a medical assessment performed by my regular doctor at least every 12 months.

I am aware that marijuana use is not advisable during pregnancy and breastfeeding. I agree to inform my physician, if I am pregnant. If I become pregnant while being treated with medical marijuana, 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 physicians.

I hereby release Medical Marijuana Services, the assessing physician, his/her clinic, my family physician, and any other involved physicians 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 posses 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, Medical Marijuana Services and my licensed commercial producer. The information may be used to contact, assess and register the patient and for analysis and research to better help our members.

I understand and acknowledge that while the assessing physician may execute a declaration that I stand to potentially benefit from medical cannabis, the assessing physician will not serve as my primary care physician. As such I agree to seek regular medical care from my primary care physician and that the assessing physician will only deal with assessing his support for my medical cannabis use. I also consent to the assessing physician notifying any specialists have seen of my decision to use medical cannabis and I accept any consequences of such notification.

I agree to notify my primary care physician myself about my intent to use cannabis medicinally as cannabis can interact with other medications. If licensed, I agree not to resell or give away any of my medication. I agree to check with local bylaws in my area. I also agree that any legal actions will take place in Ontario and be governed by the laws of Ontario, Canada.

Patient Signature				Doctor Signature			
Patient Name				Doctor Name			
Date Signed	month	day	year	Date Signed	month	day	year

Medical Marijuana Services Membership Contract

This agreement is dated _____2018.

891811-2 Canada Inc., operating as Medical Marijuana Services - "MMS"

- AND -

_____, - “Member."

MMS Membership Benefits:

1. MMS shall pre-screen Member Applications. Upon completion of the MMS Application Package, MMS will perform a preliminary assessment. Your Application will not be processed if MMS feels that you have no chance of being approved for Medical Marijuana, and you will not be charged for services;

2. Our services are Free;

3. MMS shall arrange a confidential interview by electronic means between the Member and a highly qualified member of the medical profession authorized to approve the use of medical marijuana;

4. MMS cannot guarantee that a Member shall be approved for a Medical Document (similar to a prescription). The doctor’s professional judgment is final and will not be questioned by either MMS or the Member;

5. If a Member is not approved for a Medical Document, Membership fees will be refunded in the amount of 80% of membership fee.

6. MMS provides advice on an ongoing basis regarding the best licensed producers and most appropriate strains of medical marijuana for the Member’s condition;

7. MMS Membership confers preferred status for our Members with Gold Standard licensed producers;

8. Members may purchase vaporizers and other accessories on an ‘at cost’ basis from MMS;

9. Members receive 24 hour/7 days a week emergency assistance if police or other authorities require verification of the Medical Document;

10. MMS shall provide automatic reminders when renewal of the Medical Document is imminent;

11. All medical information shall be kept in strictest confidence. MMS will never sell or allow access to the Membership roster except on orders of the police with a court-issued warrant;

Member Obligations

12. By signing this application, MMS Members undertake to be honest and forthright regarding their medical condition when preparing the Patient Assessment Form and during the medical assessment, and to openly disclose all other prescription and non-prescription medications to the physician;

13. By signing this application MMS Members acknowledge that violation of the physician-patient contract shall immediately terminate this contract;

14. By signing this application MMS Members acknowledge that they are solely responsible for any violation of the Criminal Code or the Controlled Drugs and Substances Act;

_____ _____

Member’s printed name Member’s signature

Date_____

MMS
Medical Marijuana Services