Intake Form

Name: _____ Date: _____

Address: _____ Doctor's name: _____

City: _____ Referred by: _____

Telephone number: _____ Date of birth: _____

Medical Cannabis Assessment

Chief problem for Which Cannabis Is Being Requested: _____

What year did the medical problems start? _____ (year)

What (Physically) 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, vapor, edible)

If yes, 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/day _____

Do you drink alcohol? No Yes – beerm wine or spirits How much/week _____

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

Do you use cocaine or other "street" drugs? No Yes

If yes, which ones do you use and 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 you took that FAILED to help give you relief:

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 the bowls? 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: _____

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

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Patient consent to disclose personal health information (PHI) form

Patient name: _____ D.O.B.: _____

Phone number: _____ Email: _____

Address: _____

I _____, consent to the release of personal health information (PHI) to CannabisAdvocates.ca by way of unsecured email. I also recognize that other options have been made available to me by way of faxing my personal health information directly to the office of the physician, to which I am having my medical assessment.

INITIAL _____

I _____, understand that sending personal health information through unsecure email is not necessarily at a high risk of diversion, but this risk is substantially lowered when sending personal health information by way of fax.

INITIAL _____

I _____, authorize CannabisAdvocates.ca to share my personal health information with the doctors' clinic to which I wish to have an assessment.

INITIAL _____

I _____, understand the purpose for disclosing this personal health information to CannabisAdvocates.ca and I understand that I can refuse to sign this form.

INITIAL _____

I hereby release CannabisAdvocates.ca, 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 possess medical cannabis.

Signature: _____ Date: _____

Release, Acknowledgment & Indemnity
For Patients Seeking A Medical Cannabis Document

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

I further understand that the consulting physician will not necessarily be assuming care of 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: for 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 physician or any other involved physicians such as specialists in relation to:

a) My use of cannabis as a medicine
b) My application or prescriptions for possessing, obtaining and using medical cannabis

I am well aware that physicians generally agree that medical cannabis:

- May distort perception, sight, sounds, time and touch
- May impair memory and learning
- May impair coordination
- May impair thinking and problem-solving
- May increase heart rate and reduce blood pressure
- May produce anxiety, fear, distrust or panic

INITIAL _____

<u>FOR PATIENTS Seeking a Medical Cannabis Document</u>

I am well aware that 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 medicinal 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 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 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 correlate in some cases with mental illness, such as bipolar disorder and schizophrenia

INITIAL _____

I am further well aware that the above listed medical concerns are further compounded by the lack of consistency and uniform 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 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.

INITIAL _____

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, CannabisAdvocates.ca, and my licensed commercial producer. The information may be used to contact, address and register the patient and for analysis and research to better help our members.

INITIAL _____

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

INITIAL _____

Despite all these medical 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.

INITIAL _____

This is my decision and I also do not support any claims made by my family, friends or other interested parties against CannabisAdvocates.ca and physicians.

INITIAL _____

I hereby release CannabisAdvocates.ca 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 possess medical cannabis.

INITIAL _____

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, CannabisAdvocates.ca, and my licensed commercial producer. The information may be used to contact, address and register the patient and for analysis and research to better help our members.

INITIAL _____

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 that I have seen of my decision to use CannabisAdvocates.ca and I accept any consequences of such notification.

INITIAL _____

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 have been advised and understand that a Health Canada license may not prevent police charges nor prevent police and/or local government officials from entering and inspecting my home. I agree to check with local bylaws in my area. I also agree that any legal actions will take place in Quebec and be governed by the laws of Quebec, Canada.

PRINT NAME _____

SIGNATURE _____

DATE SIGNED _____

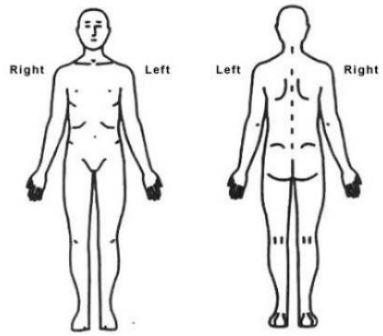
Brief Pain Inventory

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

CLIENT CONTACT INFO

NAME: _____ MALE OR FEMALE: _____

ADDRESS: _____

CITY/PROVINCE: _____ POSTAL CODE: _____

D.O.B. (DAY/MONTH/YEAR): _____ PHONE NUMBER: _____

E-MAIL: _____ SKYPE: _____

HEALTH CARD NUMBER: _____

PRIMARY DIAGNOSIS: _____

_____

_____

SECONDARY DIAGNOSIS: _____

_____

_____

LICENSED PRODUCER: _____ REQUESTED GRAMS/DAY: _____

FAMILY PHYSICIAN OR SPECIALIST: _____

ADDRESS/CITY OF FAMILY PHYSICIAN OR SPECIALIST: _____

_____

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 panic 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 for 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 like 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: Zigmond AS et al. Acta Psychiatrica Scandinavica 1983; 67: 361-370