ALL ACCESS MEDICAL

Patient Information

First name and Surname: _____

Address: _____

DOB (D/M/Y): _____ Phone: _____

Email: _____ Gender (circle): M F

Preferred method(s) of contact (circle): Email Phone Video In person

Reason for seeking medical attention: _____

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 initializing, you understand and agree to the information disclosed.
- ☐ If you have questions or do not understand the information below, consult with the attending Nurse Practitioner 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.

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: Caner, 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 and mental health

Patient Signature: _____ Date: _____

Please initial if you understand and agree the following statements:

_____ 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 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 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, 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.

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_____ 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 provided 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 Marijuana for Medical Purposed 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 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 contains 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 responsibility for any harm resulting to me and/or other individuals as a result of my medical marijuana use.

Patient Signature: _____ Date: _____

Medical History

- Did you bring any medical records with you today (circle)? Yes No
  If yes, what did you bring?
  _____
  _____
  _____

- Do you have a primary care physician(circle)? Yes No
  (If yes, please provide details below)

  Name:_____Address:_____Phone_____

- Have you talked to your primary care physician about medical marijuana (circle)? Yes No

Current medical complaint(s) or concern(s):_____
_____
_____

Activities of Daily Living Assessment:

Please check if any of the following activities are substantially limited (i.e. pain/weakness/impaired strength or ability) by the medical condition for which you seek medical marijuana certification?

___ caring for myself
___ performing manual tasks
___ hearing
___ eating
___ seeing
___ bending
___ standing
___ sleeping
___ learning
___ speaking
___ other (please specify below)

___ lifting
___ thinking
___ reading
___ breathing
___ social interaction
___ communicating
___ concentrating
___ operation of major bodily function
___ working

_____
_____

Marijuana History:

- Do you presently use marijuana to treat your medical condition? ____ Yes ____No

- Does marijuana provide relief for your symptoms (if yes, please describe, e.g. Decreases pain, improves sleep, etc.): _____
  _____
  _____

- How effective is marijuana in treating the symptoms of your condition?

_____Very effective _____Effective _____Somewhat effective

- How does marijuana compare with your usual prescribed medicines in relieving your symptoms?

  ___ Prescribed medicines work much better ___ Marijuana works a little better than prescribed medicines
  ___ Prescribed medicines work a little better ___ Marijuana works much better than prescribed medicines
  ___ Prescribed medicines work no better ___ Marijuana and prescribed medicines work best together

- Does use of marijuana modify your use of other drugs or medications (circle)? Yes No

If yes, what dosage?
Please Explain: _____

_____

- Does use of marijuana modify your use of alcohol (circle)? Yes No

Please Explain: _____

_____

- Frequency of marijuana use as a medicine (i.e. daily, weekly, monthly, etc.):
  _____

- Method of marijuana use as a medicine: Vaporize Ingest Smoke

  Other_____

- You understand that smoking is harmful to your lungs and is not medically advised(circle)? Yes No

- Have you had any negative/adverse reaction from use of marijuana? No Yes
  If yes, please describe: _____

_____

- Additional information that you consider relevant to your past medical history (i.e. surgeries, medical investigations, pending diagnoses):
  _____

_____

- Have you been denied a prescription for medical marijuana use by another MD in the past (circle)?
  Yes No
  (if yes, please explain_____

- Are you currently attending or have you attended any substance abuse or rehabilitation program (circle)?
  Yes No
  If yes, provide details: _____
  _____
  _____

- Do you ever have thoughts of suicide or have you ever attempted suicide (circle)? Yes No

  If yes, please provide details: _____
  _____
  _____

Patient Signature: _____ Date: _____

CONSENT FOR RELEASE OF MEDICAL INFORMATION

PHYSICIAN INFORMATION

Physician Name: _____ Phone # : _____ Fax # : _____

PATIENT INFORMATION

Mr/Mrs Last Name:_____ Gender: M F
Ms/Mrs First Name: _____

Date of Birth (M/D/Y): _____ Provincial Health Card: _____

Address:
City: _____Province: _____ Postal Code: _____

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

PATIENT MEDICAL HISTORY

Please provide documentation from the last 12 months pertaining to the following medical condition(s):

_____
_____
_____

Please note:

Our Nurse Practitioner is requesting relevant medical reports on your patient for the purpose of a medical marijuana consultation. All information is kept strictly confidential. Please note: We are not taking on the patient as a family doctor and as such we do not require their entire files to be transferred.

Patient Signature: _____ Date: _____