Referral Source

No.

Cannascribe
Medical Marijuana Prescription Service

PATIENT ASSESSMENT FORM

Date | Day | Month | Year

Patient Assessment Form

For Patients Seeking a Medical Cannabis Prescription

General Details

Patient's Name: First Name | Middle Name | Last Name

Health Card # | Skype:

Date of Birth: DD/MM/Year | Email:

Current Age: | Gender: Male: Female: Other:

Best time to contact: | If female, are you pregnant or nursing: Yes: No:

Contact Information (if different from business location)

Address:

City: | Prov: | Postal:

Home: | Mobile:

General Practitioner Information:

Doctor's Name: First Name | Last Name

Date of Last Visit: Day | Month | Year

Reason for Last Visit:

Are you seeing a specialist: Yes: No:

Specialist's Name: First Name | Last Name

Date of Last Visit: Day | Month | Year

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Patient Assessment Form

Your Medical Condition and Symptoms

Primary Condition:

Check symptoms associated with your Primary Condition.

Indicate level of symptom severity. Level 1 - not severe. Level 5 - very severe

Pain:	1	2	3	4	5	Anxiety:	1	2	3	4	5
Muscle Spasms:	1	2	3	4	5	Depression:	1	2	3	4	5
Mobility:	1	2	3	4	5	Concentration / Focus:	1	2	3	4	5
Headache:	1	2	3	4	5	Sleep Disturbance:	1	2	3	4	5
Seizures:	1	2	3	4	5	Visual Disturbance:	1	2	3	4	5
Involuntary Movements:	1	2	3	4	5	Weight Loss:	1	2	3	4	5
Nausea / Vomiting:	1	2	3	4	5						
Low Energy:	1	2	3	4	5						
Diarrhea:	1	2	3	4	5						
Constipation:	1	2	3	4	5						
Medication Side Effects:	1	2	3	4	5						
Other: _____	1	2	3	4	5						

Medical History

How much does your condition affect your daily routine? 1 2 3 4 5

Indicate level of symptom severity. Level 1 - not severe. Level 5 - very severe

Comments:

How much does your condition affect your ability to work? 1 2 3 4 5

Indicate level of symptom severity. Level 1 - not severe. Level 5 - very severe

Comments:

Current Medications:

Please indicate dosage

Drug Allergies:

What therapies have you tried? Please check all that apply.

Indicate level of effectiveness — Not Effective (**NE**), Effective (**E**), Very Effective (**VE**).

	NE	E	VE	
Physiotherapy:				Current Prescription
Chiropractic:				Indicate Dosage
Naturopathic/Homeopathic:				
Counseling/Psychotherapy:				
Therapeutic Injections:				
Acupuncture:				

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Patient Assessment Form

Have you been diagnosed with any dependence on any drug, prescribed or otherwise? Yes: ◯ No: ◯

Have you previously used cannabis for symptom relief? Yes: ◯ No: ◯

Have you suffered from Psychotic Illness currently or in the past? Yes: ◯ No: ◯

Has a close member suffered from Psychotic Illness? Yes: ◯ No: ◯

Would you feel at risk using cannabis outside your current medical treatment? Yes: ◯ No: ◯

Do you suffer from heart disease? Yes: ◯ No: ◯

How much cannabis do you use 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 Mood: ☐

Improve Appetite: ☐ Improve Sleep: ☐ Involuntary Movements: ☐

Why is cannabis appropriate as a medical treatment for you?

Signature

Name: First Name Last Name

Date signed: Day Month Year

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Patient Release Form

General Details

Patient's Name: First Name | Middle Name | Last Name

Date of Birth: DD/MM/Year

Current Age: | Gender: | Male: | Female: | Other:

Address: Line 1 | Line 2

City: | Prov: | Postal:

I understand that this Release and Acknowledgment 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 authorization 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 symptoms 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 physician or any other involved physicians (such as specialists) in relation to:

1. my use of cannabis as a medicine; and
2. 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 (sights, sounds, touch, time);
- May impair memory and learning
- May impair coordination
- May impair thinking and problem-solving
- May increase heart rate and reduces blood
- May produce anxiety, fear, distrust or panic.

Initials

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Patient Release Form

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;
- The long-term health and psychological risks associated with the use of medical cannabis;
- The degree to which regular consumption of medical cannabis;
    - may contribute to pulmonary infections and respiratory cancer;
    - may damages 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 n the possibility of dangerous pulmonary infections, including pneumonia;
    - may weaken various natural immune mechanisms, including macrophages and T-cells.
    - may correlate in some cases with mental illness, such as a bipolar disorder and schizophrenia

Initials

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 precise 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.

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

I am aware that ingesting a high dose of medical cannabis can cause nausea and disorientation.

Initials

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

Initials

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

Initials

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Patient Release Form

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.

Initials

I hereby release 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.

Initials

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

Initials

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/her support from 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.

Initials

Signature

Date signed: Day | Month | Year

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HADS (Hospital Anxiety and Depression Scale)

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

	Yes, Definitely	Yes, Sometimes	No, Not much	No, Not at all
1) I wake early and then sleep poorly the rest of the night.	3	2	1	0
2) I get frightened or have panicked feelings for no apparent reason.	3	2	1	0
3) I feel miserable and sad.	3	2	1	0
4) I feel anxious leaving 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 feel scared or frightened.	3	2	1	0
8) I feel life is not worth living.	3	2	1	0
9) I still enjoy the things I used to do.	3	2	1	0
10) I am restless and cannot keep still.	3	2	1	0
11) I am more irritable than usual.	3	2	1	0
12) I feel as if I have slowed down.	3	2	1	0
13) Worrying thoughts constantly go through my mind.	0	1	2	3
14) I have a good appetite.	0	1	2	3
Total: /42				

Modified by Cannascribe Inc. from Source: Ziqmond AS et al. Acta Psychiatric Scandinavia 1983, 67: 361-370

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Brief Pain Inventory

Patients Name: First Name | Middle Name | Last Name

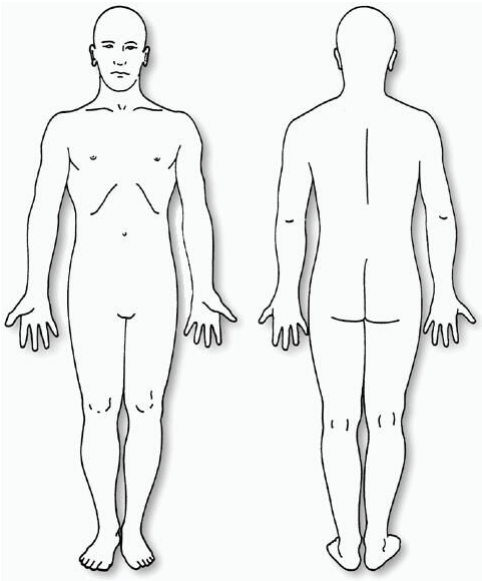
Health Card #

Date: Day | Month | Year

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

Yes: ☐ No: ☐

2. On the diagram below, shade in where you have been experiencing pain, and put an X where the pain is most severe kinds of pain today?



3. Please rate your pain by circling one of the numbers below. This should indicate your pain at its **worst** in the last 24 hours.

1	2	3	4	5	6	7	8	9	10

No Pain — Very Severe Pain

4. Please rate your pain by circling one of the numbers below. This should indicate your pain at its **least** in the last 24 hours.

1	2	3	4	5	6	7	8	9	10

No Pain — Very Severe Pain

5. Please rate your pain by circling one of the numbers below. This should indicate your **average** pain in the last 24 hours.

1	2	3	4	5	6	7	8	9	10

No Pain — Very Severe Pain

6. Please rate your pain by circling one of the numbers below. This should indicate your pain **right** now.

1	2	3	4	5	6	7	8	9	10

No Pain — Very Severe Pain

7. In the past 24 hours, how much relief have pain treatments/medications provided?

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

No Relief — Complete Relief

8. Circle one number that indicates how, in the past 24 hours, pain has interfered with your;

a) General Activity:

1	2	3	4	5	6	7	8	9	10

No Interference — Complete Interference

Modified by Cannascribe Inc. from Source: McCaffery M, Pasero C: Pain: Clinical Manual, Page 61, 1999, Mosby, inc. from Pain Research Group, Department of Neurology, University of Wisconsin-Madison Bennett M1 2001 PAIN: 92 147-157

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Brief Pain Inventory

b) Mood:

1	2	3	4	5	6	7	8	9	10

No Interference — Complete Interference

c) Mobility:

1	2	3	4	5	6	7	8	9	10

No Interference — Complete Interference

d) Normal work: (Includes outside, home, and housework)

1	2	3	4	5	6	7	8	9	10

No Interference — Complete Interference

e) Relations With Others:

1	2	3	4	5	6	7	8	9	10

No Interference — Complete Interference

f) Sleep:

1	2	3	4	5	6	7	8	9	10

No Interference — Complete Interference

g) Enjoyment of life:

1	2	3	4	5	6	7	8	9	10

No Interference — Complete Interference

h) Appetite:

1	2	3	4	5	6	7	8	9	10

No Interference — Complete Interference

i) Ability to Concentrate:

1	2	3	4	5	6	7	8	9	10

No Interference — Complete Interference

10. In the area(s) where you feel pain, do you experience pins and needles or any tingling/prickling sensations?

Yes: ☐ No: ☐

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

Yes: ☐ No: ☐

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

Yes: ☐ No: ☐

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

Yes: ☐ No: ☐

14. In the area of pain, does the skin feel unusually hot, or as though it is burning?

Yes: ☐ No: ☐

15. Gently rub the painful area with your index finger, 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 on 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

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