#101-2296 McCallum Road
Abbotsford, BC V2S 3P3
T: (604) 859-3677 F: (604) 859-3670
www.greenleafmedicalclinic.com

CONSENT FOR RELEASE OF MEDICAL INFORMATION

<table>
<tr><th colspan="12">PHYSICIAN INFORMATION</th></tr>
<tr><td colspan="5">Physician:</td><td colspan="3">Phone #</td><td colspan="4">Fax #</td></tr>
<tr><th colspan="12">PATIENT INFORMATION</th></tr>
<tr><td colspan="2">Last:</td><td colspan="3">First:</td><td colspan="3">Middle:</td><td colspan="2">☐ Mr. ☐ Mrs.
☐ Ms. ☐ Miss.</td><td colspan="2">Sex:
☐ M ☐ F</td></tr>
<tr><td colspan="2">Date of Birth:
Month</td><td>Day</td><td colspan="2">Year</td><td colspan="7">Provincial Health Care #:</td></tr>
<tr><td colspan="4">Address:</td><td colspan="3">City:</td><td colspan="3">Province:</td><td colspan="2">Postal Code:</td></tr>
<tr><td colspan="3">Home Phone #:</td><td colspan="4">Work Phone #:</td><td colspan="5">Cell Phone #:</td></tr>
<tr><th colspan="12">PATIENT MEDICAL HISTORY</th></tr>
<tr><td colspan="12">Please provide documentation from the last 12 months pertaining to the following medical condition(s):</td></tr>
<tr><th colspan="12">Please note:</th></tr>
<tr><td colspan="12">Our physician 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.</td></tr>
<tr><td colspan="7">Patient Signature:</td><td colspan="5">Date:</td></tr>
</table>

Greenleaf
MEDICAL CLINIC

PATIENT INTAKE

PATIENT INFORMATION

First Name: Last Name: Date of Birth:

Gender: Personal Health Care Number:

Home Phone: Cell Phone: Work Phone:

Email Address:

INDICATION FOR CANNABIS

Please check the medical condition(s) / problem(s) for which you wish to use medical cannabis (Check all that apply):

- ☐ ADD/ADHD
- ☐ Alzheimer's Disease
- ☐ Anxiety
- ☐ Appetite
- Arthritis
  - ☐ Osteoarthritis
  - ☐ Psoriatic Arthritis
  - ☐ Rheumatoid Arthritis
- ☐ Back and Neck Pain
- ☐ Bladder Pain
- ☐ Brain Injury
- ☐ Cancer
- ☐ Cancer Symptoms
- ☐ Chronic Pain
- ☐ Colitis
- ☐ Complex Regional Pain Syndrome
- ☐ Other:
- ☐ Crohn's Disease
- ☐ Degenerative Disc Disease
- ☐ Depression
- ☐ Eating Disorders
- ☐ Epilepsy
- ☐ Essential Tremors
- ☐ Fibromyalgia
- ☐ Gastrointestinal Disorders
- ☐ Glaucoma
- ☐ Head Injury
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Irritable Bowel Syndrome
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Libido
- ☐ Menopause
- ☐ Migraines
- ☐ Multiple Sclerosis
- ☐ Muscle Spasms
- ☐ Muscular Dystrophy
- ☐ Nausea
- ☐ Nerve Pain
- ☐ Parkinson's Disease
- ☐ Pelvic Pain
- ☐ Post Operative Surgery Pain
- ☐ PMS/Menstrual Cramps
- ☐ PTSD
- ☐ Repetitive Strain Injury
- ☐ Seizures
- Sleep Disorders
- ☐ Spinal Cord Injury/Disease

Explain ALL conventional therapies attempted to assist you with the management of your medical condition(s) in which you are seeking to use cannabis and explain how these treatments have not been successful.

MEDICAL HISTORY

Please give a brief description of your previous medical history:

List the name, last date seen and type of health care provider (Doctor, chiropractor, therapist, counselor, and/or specialist) that you consult for your medical condition(s):

Name	Date Last Seen	Type of Health Care Provider

PSYCHIATRIC HISTORY

Are you currently experiencing any of the following?

Mania (bipolar disorder) ☐ Yes ☐ No
Schizophrenia ☐ Yes ☐ No
Depression ☐ Yes ☐ No
Using Sedatives/psychoactive drugs ☐ Yes ☐ No

Are you currently or previously suicidal? ☐ Yes ☐ No

Do you have any history of substance abuse such as: alcohol, heroin, cocaine, LSD, marijuana, ecstasy, GHB, prescription drug abuse (narcotics or Benzo)? ☐ Yes ☐ No

CURRENT PRESCRIPTIONS AND OVER THE COUNTER SUPPLEMENTS

PREVIOUS MEDICATIONS TRIED (Check all that apply)

☐ Gabapentin	☐ Lyrica	☐ Anti-Anxiety
☐ Antidepressants	☐ Muscle Relaxants	☐ Anti-inflammatories
☐ Narcotics/Opioids	☐ Methadone	☐ Lidocaine/Ketamine
☐ Nabilone	☐ Tramadol	☐ Sleep Medication
☐ Other:		

ALLERGIES (Please list all allergies)

HISTORY

Any history of heart attack, chest pain, stroke? ☐ Yes ☐ No

Are you pregnant or breastfeeding? ☐ Yes ☐ No

Do you have an allergy to cannabis? ☐ Yes ☐ No

Do you have chronic bronchitis (lung disease)? ☐ Yes ☐ No

Any history of high blood pressure? (hypertension) ☐ Yes ☐ No

Any history of low blood pressure? (hypotension) ☐ Yes ☐ No

Do you have children in the house or who visit? ☐ Yes ☐ No

If yes, how old are they? ________________

Are you working outside of the home? ☐ Yes ☐ No

Do you work in a safety sensitive or cognitively demanding occupation?
(ie. Construction work, heavy machinery, policeman, etc.) ☐ Yes ☐ No

Do you drive a car? ☐ Yes ☐ No
Do you travel outside of Canada? ☐ Yes ☐ No Within Canada? ☐ Yes ☐ No

Are you on disability? ☐ Yes ☐ No If yes, which one? (PWD, CPP, Workplan)________________________________

Is your annual income less than $30,000? ☐ Yes ☐ No

If yes, bring in a notice of assessment as you will qualify for compassionate pricing.

DRUG AND ALCOHOLHISTORY

Do you have a previous history of smoking? Yes No

If yes, how many years? ___________

Do you currently use:

Tobacco ☐ Yes ☐ No If yes, how many cigarettes perday? ___________

Alcohol ☐ Yes ☐ No If yes, how many drinks perweek? ___________

Have you ever been evaluated by another physician formedical marijuana? ☐ Yes ☐ No

Do you use marijuana to reduce or eliminate the use of any medications that have been prescribed for your medicalcondition? ☐ Yes ☐ No

If yes, which medication(s) have you reduced or eliminated and why? Please include dosage details

How often do you usecannabis?

☐ Everyday ☐ Every other day ☐ 1-2 times per week ☐ More than once a month ☐ Other

How have you used cannabis? (Please check all that apply)

☐ Smoking (joints) ☐ Vaporizing ☐ Ingestion ☐ Topical

If you own a vaporizer, which vaporizer do you own? ___________________________________

Do you/did you useit recreationally_________or for medicalreasons? ___________

What strains have you used? (Check all that apply)

☐ Indica ☐ Sativa ☐ Hybrid ☐ All

How much marijuana do you currently use per day, in grams? ___________

How many times per day do you use cannabis? ___________

Have you had any serious reaction to cannabis? ___________

Patient Health Questionaire

(G A D - 7)

Over the last 2 weeks, how often have you been bothered by the following problems? (Use "✔" to indicate your answer)	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(For office coding: Total Score T____ = ____ + ____ + ____)

Patient Health Questionaire

(P H Q - 9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving arounda lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING __*0*__ + ______ + ______

\+ ______ **=Total Score:** ______

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

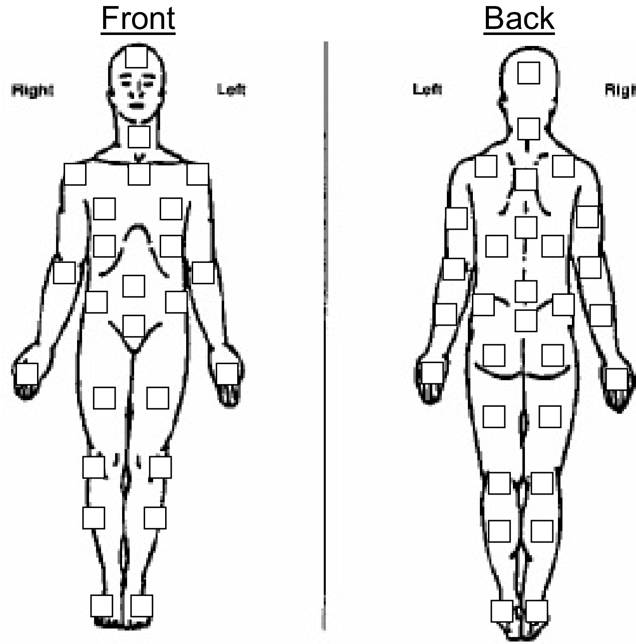
Inventory (Short Form)

Developed by Charles S. Cleeland, PhD

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, check the areas where you feel pain.**



3. **Please rate your pain by marking the box beside the number that best describes your pain at its worst 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

4. **Please rate your pain by marking the box beside the 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 marking the box beside the number that best describes your pain on the 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 marking the box beside the number that tells 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

7. What treatments or medications are you receiving for your pain?

8. In the last 24 hours, how much relief have pain treatments or medications provided? Please mark the box below the 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. Mark the box beside the number that describes how, during the past 24 hours, pain has interfered with your:

A. General Activity

☐ 0 Does Not Interfere ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Completely Interferes

B. Mood

☐ 0 Does Not Interfere ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Completely Interferes

C. Walking ability

☐ 0 Does Not Interfere ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Completely Interferes

D. Normal Work (includes both work outside the home and housework)

☐ 0 Does Not Interfere ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Completely Interferes

E. Relations with other people

☐ 0 Does Not Interfere ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Completely Interferes

F. Sleep

☐ 0 Does Not Interfere ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Completely Interferes

G. Enjoyment of life

☐ 0 Does Not Interfere ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Completely Interferes

Opioid Risk Tool(ORT)

Questionnaire developed by Lynn R. Webster, MD to assess risk of opioid addiction.

Please mark each box hat applies. Only complete the column that refers to **your gender**.

	Female	Male
IS THERE A FAMILY HISTORY OF SUBSTANCE ABUSE		
Alcohol	☐ 1	☐ 3
Illegal Drugs	☐ 2	☐ 3
Prescription Drugs	☐ 4	☐ 4
IS THERE A PERSONAL HISTORY OF SUBSTANCE ABUSE		
Alcohol	☐ 3	☐ 3
Illegal Drugs	☐ 4	☐ 4
Prescriptiondrugs	☐ 5	☐ 5
Age between 16 45 years	☐ 1	☐ 1
History of preadolescent Sexual abuse	☐ 3	☐ 0
PSYCHOLOGICDISEASE		
ADD, OCD, bipolar,schizophrenia	☐ 2	☐ 2
Depression	☐ 1	☐ 1
Scoring Totals		

Patient Signature:________________________________ Date: ________________________________

Privacy Policy

In the event that the company proceeds with the reorganization, sale, lease, merger or amalgamation or any other type of disposal or financing of the company or a portion of the company or of any of the business or assets of the company, the company shall comply with the requirements set out in subsection 20(3) of the Personal Information Protection Act (British Columbia).

The company may collect, use, share and access different types of information or data about the company's clients and/or patients in such ways that do not identify such individuals directly (e.g. by name) or indirectly (e.g. by date of birth) and for statistical purposes only. Such information may include personal characteristics or other information about which an individual has a reasonable expectation of privacy (e.g., age, ethnicity, health history, life experience, social status). The company does not release any information that could identify individuals without their consent. The company covenants that all personal information (within the meaning attributed thereto in applicable legislation in British Columbia) of or with respect to the patients shall only be used, disclosed or dealt with in strict compliance with applicable privacy legislation.

Who has Access to Information Collected?

We strictly control access to your personal information to our employees who need this information in order to serve you or to employees who analyze our performance in order to measure and improve our services. Employees are kept up-to date with regard to the privacy and security practices of MedicalMarijuana.ca and the Greenleaf Medical Clinic.

We reserve the right to co-operate with local, provincial and national officials in any investigation requiring either personal information including any personal information provided online through MedicalMarijuana.ca or reports about lawful and unlawful user activities on the Web site.

If you ask us, we will remove any information about you from our files, unless some legitimate purpose makes its reasonable for us to retain it for some additional time. We will also review our files from time to time with a view to identifying and deleting stale information.

INFORMED CONSENT

By signing this document, you acknowledge that you have been informed of and understand the following:

1. The physicians, the clinic staff, and/or clinic representatives are neither providing nor dispensing medical marijuana.

2. Prior to your appointment, you are required to submit a copy of your most recent government issued photo ID.

3. The physician or clinic staff will NOT be providing or discussing information regarding any other way of obtaining medical marijuana other than from a Health Canada approved licensed producer.

4. If you are a BC resident, clinic staff will review your PharmaNet information. You are required to complete the "Patient Consent to Access PharmaNet" form found at this link: https://www.health.gov.bc.ca/exforms/mpap/4530_Appendix1.pdf

5. The physicians are evaluating you for the use of medical cannabis and will make their recommendation based in part, on the medical information you have provided. It is your responsibility to ensure that there is no misrepresentation of your medical information submitted in order for you to obtain a recommendation to use cannabis for your medical condition.

6. You agree to only use medical cannabis for the treatment of your medical condition as agreed upon by the physician and not for recreational or non-medical purposes.

7. The physician is addressing specific aspects of your medical care and, unless otherwise stated, is in no way establishing herself as your primary care physician.

8. Should the physician approve you for the use of medical cannabis, it is your responsibility to ensure that a renewal appointment is made **one month** prior to your expiry date. During your renewal appointment the physician will re-evaluate the possible continuance of cannabis.

9. You understand that it is your responsibility to stay informed regarding provincial and federal laws regarding the possession, use, sale/purchase and/or distribution of medical marijuana.

10. Health Canada, the physicians and the Greenleaf Medical Clinic staff advise you that using cannabis is prohibited while driving or performing hazardous tasks such as operating heavy machinery. The same applies to safety-sensitive occupations such as health professionals and the supervision of children. Depending on dosage and administration, impairment can last over 24 hours following last usage.

11. The potential side effects from the use of marijuana include, but are not limited to the following; dizziness, anxiety, confusion, sedation, low blood pressure, impairment of short-term memory, euphoria, difficulty in completing complex tasks, suppression of the body's immune system, inability to concentrate, impaired motor skills, paranoia, psychotic symptoms, general apathy, depression and/or restlessness.

12. Marijuana may exacerbate schizophrenia in persons predisposed to the disorder.

13. Marijuana use may also cause excessive talking and eating, alter your perception of time and space and impair your judgment.

14. You 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.

15. Smoking marijuana may cause respiratory problems and harm, including; bronchitis, emphysema and laryngitis. In the opinion of many researchers, marijuana smoke contains known carcinogens (chemicals that cause cancer) and smoking marijuana may increase the risk of respiratory diseases and cancers in the lung, mouth and tongue. In addition, marijuana smoke contains harmful chemicals known as tars. If you begin to experience respiratory problems when using marijuana, you agree to stop using it and report your symptoms to a physician.

16. The physicians and/or the Greenleaf Medical Clinic staff will inform you of alternatives to smoking marijuana.

17. The risk, benefits and drug interactions of marijuana are not fully understood. If you are taking medication or undergoing treatment for any medical condition, you understand that you should consult with your primary care physician(s) before using marijuana and that you should not discontinue any medication or treatment previously prescribed unless advised to do so by your primary care physician.

18. Individuals may develop a tolerance to and/or dependence on marijuana. If you develop signs of withdrawal, which can include; feelings of depression, sadness, irritability, insomnia, restlessness, agitation, loss of appetite, trouble concentrating, sleep disturbances, and unusual tiredness, contact the Greenleaf Medical Clinic.

19. Symptoms of marijuana overdose include but are not limited to; nausea, vomiting, hacking cough, disturbance in heart rhythm, numbness in hands, feet, arms or legs, anxiety attacks and incapacitation. If you experience these symptoms, you agree to contact your primary care physician, call 911 or go to the nearest emergency room.

20. If the Greenleaf Medical Clinic subsequently learns that the information you have furnished is false or misleading, the recommendation by the physician for marijuana may be revoked. You agree to promptly meet the Greenleaf Medical Clinic and/or provide additional information in the event of any inaccuracies or misstatements in the information you have provided.

21. Recommendations made by the Greenleaf Medical Clinic about Licensed Producers, strains and methods of intake are recommendations **ONLY**. The Greenleaf Medical Clinic reserves the right to discuss your information with your licensed producer and you agree with your licensed producer sharing information about your application and recommendation with the Greenleaf Medical Clinic.

22. If you do not understand any of the above, you agree to contact the Greenleaf Medical Clinic for clarification.

23. The Greenleaf Medical Clinic is a private clinic that charges a fee for service. The clinic has a 7 day cancellation policy. Failure to cancel your appointment within the 7 days will result in a $200.00 charge. To cancel an appointment, you must speak directly with one of the clinics medical office assistants. Cancellations by email or phone message will not be accepted.

24. I authorize any Greenleaf Medical Clinic physician to make direct contact with a current, treating primary care physician to determine whether excessive use of marijuana has harmed myself, the patient.

25. I understand that the information I have been asked to provide to the Greenleaf Medical Clinic and/or the Physician is for the diagnosis and treatment of the medical condition(s) for which I want to access medical marijuana. I understand that if I have not accurately and completely disclosed the requested information, it may adversely impact the physician's ability to diagnosis my condition and recommend appropriate medical marijuana treatment.

Patient Signature: ______________________ Date: ______________________

RELEASE FORM FOR MEDICAL PRACTITIONERS

Marihuana for Medical Purposes Regulations

I,____

agree not to make any claim or complaint or commence any proceedings against any Greenleaf physician and/or the Greenleaf Medical Clinic staff in relation to the application process under the Marihuana for Medical Purposes Regulations (MMPR) or my use of marihuana.

I release the Greenleaf Medical Clinic physician and staff from any or all actions, causes of actions, claims, complaints and demands for damages, loss or injury whatsoever arising directly or indirectly as a consequence of my application under the Marihuana for Medical Purposes Regulations or my use of marihuana. This release from liability is to be binding on my heirs, executors and assigns.

____

Signature of Applicant　　　　　　　　　　Date

____

Signature of Witness　　　　　　　　　　Date

#101-2296 McCallum Road, Abbotsford, BC V2S 3P4
T: 1-877-513-4769 F: 1-604-859-3670
www.greenleafmedicalclinic.ca

TREATMENT AGREEMENT

Because we take our responsibilities to authorize and supervise the medical use of marijuana (dried cannabis) very seriously, we ask you to read, understand, and sign this form.

---

1. I request Dr. Caroline MacCallum, FRCPC (Internal Medicine), B Sc. Pharmacy to sign a medical document for me under the Health Canada MMPR legislation, so that I may legally use marijuana to treat my medical condition.
2. I agree to receive a medical document for marijuana only from one physician, Dr. Caroline MacCallum, FRCPC (Internal Medicine), B Sc. Pharmacy.
3. I agree to consume no more marijuana than the doses authorized for me by Dr. Caroline MacCallum, FRCPC (Internal Medicine), B Sc. Pharmacy. I will not request a refill before the agreed-upon refill date.
4. I agree to not distribute my marijuana to any other person, for personal use or for sale. I am aware that redistribution of any marijuana for sale is an illegal activity.
5. I am aware that using marijuana is associated with psychosis in persons who are still undergoing neurodevelopment (brain growth). Therefore, I will ensure that no person under the age of 25 years has access to my marijuana.
6. I agree to the safe storage of my marijuana.
7. 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.
8. I will not use controlled substances that were prescribed by another doctor unless Dr. Caroline MacCallum, FRCPC (Internal Medicine), B Sc. Pharmacy, is aware of this.
9. I agree to testing (eg, urine drug screening) when and as requested by my physician.
10. I agree to have an office visit and medical assessment at least every 3 to 6 months.
11. I understand that Health Canada has provided access to marijuana by signed medical document from a physician for the treatment of certain medical conditions, but despite this, Health Canada has not approved marijuana as a registered medication in Canada.
12. I understand that my physician may not be knowledgeable about all of the risks associated with the use of a non-Health Canada approved substance like marijuana.
13. I agree to communicate to my physician, Dr. Caroline MacCallum, FRCPC (Internal Medicine), B Sc. Pharmacy, any experiences of altered mental status or possible medical side effects of the use of marijuana.
14. I accept full responsibility for any and all risks associated with the use of marijuana, including theft, altered mental status, and side effects of the product.
15. I am aware that marijuana use is not advisable during pregnancy and breastfeeding. I agree to inform my physician, Dr. Caroline MacCallum, FRCPC (Internal Medicine), B Sc. Pharmacy, if I am pregnant.
16. I am aware that smoking any substance can cause harm and medical complications to my breathing and respiratory status. I will avoid smoking marijuana. I will avoid mixing marijuana with tobacco. I agree to use my marijuana only by vaporizer or as an edible product.
17. I am aware that my physician may discontinue authorizing marijuana for my condition if he or she assesses that the medical or mental health risk or side effects are too high.
18. I agree to see specialists or therapists about my condition at my physician's request.
19. I agree to avoid driving a vehicle or operating heavy machinery for at least 4 hours after the use of marijuana, and for longer if I feel any persistent negative effects on my ability to drive.
20. As per the Health Canada MMPR legislation, I agree to purchase my marijuana only from a licensed producer. I am aware that possession of marijuana from other sources is illegal.
21. I am aware that any possible criminal activity related to my marijuana use may be investigated by legal authorities and criminal charges may be laid. During the course of an investigation, legal authorities have the right to access my medical information with a warrant.
22. Following the terms of this contract is one of the conditions I must meet to access marijuana for treatment. I understand that if I violate any of this agreement's terms, my physician may stop authorizing my use of cannabis.
23. Dr. Caroline MacCallum, FRCPC (Internal Medicine), B Sc. Pharmacy, has the right to discuss my health care issues with other health care professionals or family members if it is felt, on balance, that my safety outweighs my right to confidentiality.

Patient's printed name ____________________ Patient's signature ____________________

Date ____________________ Practitioner's signature ____________________

College of Family Physicians of Canada (CFPC) Authorizing Dried Cannabis for Chronic Pain or Anxiety: Preliminary Guidance

Ministry of Health

PHARMANET
Patient Consent to Access PharmaNet

The Province of British Columbia has established the provincial pharmacy network and database known as "PharmaNet" pursuant to section 37 of the *Pharmacists, Pharmacy Operations and Drug Scheduling Act,* R.S.B.C. 1996, c. 363, and which may be continued pursuant to section 13 of the *Pharmacy Operations and Drugs Schedule Act,* S.B.C., 2003, c. 77 should it be proclaimed in force during the term of this Agreement.

I, ________________________________, authorize Dr. C. MacCallum or Dr. E. Nichol
Name of Patient (print) *Name of Physician (print)*

and persons directly supervised by him/her to access my personal health information contained within PharmaNet for the purpose of providing therapeutic treatment or care to me, or for the purpose of monitoring drug use by me.

I understand that withdrawal of this consent must be in writing and delivered to the above-named physician.

Executed at ________________________, this _______ day of _______________, 20____.

SIGNED AND DELIVERED by)

______________________________________)
Patient (print))

in the presence of:)

______________________________________) ______________________________
Witness (signature)) *Patient (signature)*

______________________________________)
Witness (print))

______________________________________)
(Dated))

#101 - 2296 McCallum Road
Abbotsford, B.C
V2S 3P3
T: 1-877-513-4769
F: 1-604-859-3670
info@greenleafmc.ca
www.greenleafmedical.com

Name: ____

Address: ____

City: __________________________ **Province:** _________

Phone: (_____) ______ - _______

Credit Card Information:

MasterCard (__) **Visa** (__) **AMEX** (__) **Other** (__)

Card#: _____________________________________ **Expiry:** ____ / ______

CRV CODE________ **This is the last 3 digits on the back of your credit card

Name of Card Holder: ____

The Greenleaf Clinic and/or Maple Reef Plant Products is/are hereby authorized and directed to accept telephone or verbal or written orders from the above noted person and to debit charges to the above noted credit card account or the purchase of services and consultations provides by GLMC and/or Maple Reef Plant Products.

The undersigned warrants and represents that he/she is authorized to sign for charges to the credit card(s) listed above and be executing the agreement consents to the charges being processed on the same and further consents to the execution by any representative of GLMC and/or Maple Reef Plant Products of any charge slip or other document required by GLMC and/or Maple Reef Plant Products' credit card company to support or process the charges incurred.

Card Holder Signature: ___________________________

Date: _____________(MM/DD/YYYY)