Greenleaf
MEDICAL CLINIC

#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

PHYSICIAN INFORMATION					
Physician:		Phone #		Fax #	
PATIENT INFORMATION					
Last:	First:	Middle:	☐Mr. ☐Mrs. ☐Ms. ☐Miss.	Sex: ☐M ☐F	
Date of Birth: *Month* / *Day* / *Year*			Provincial Health Care #:		
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 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.					
Patient Signature:		**Date:**			

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PATIENT INTAKE FORM

Medicinal Marijuana Consultation Intake

Last Name_____ First Name _____ DOB_____ Age_____

Address _____ City _____ Postal Code_____

Home #_____ Health Card_____ (please include two letters if you have the green card)

Email _____

How did you hear about us?

Greenleaf Website _____

Dr's Office _____

Other _____

VSee name (if seeing the physician through telemedicine) _____

I understand that the Greenleaf Medical Clinic does not replace my family doctor. _____ (Initial)

Medical Marijuana Consultation is a thorough medical history consult regarding symptoms and diagnosis where Cannabis would be an appropriate medicine. Additional forms, including ODSP, and Insurance will require a fee.

By signing this contract you are agreeing to the terms outlined above.

Signature _____ Date _____

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PATIENT ASSESSMENT FORM

Please read the following carefully.

I cannot administer cannabis as medicine to help you treat your current condition unless this form is filled out correctly and accurately.

Please take the time to fill out this form so I can properly assess if you are a good candidate for medicinal marijuana. Please answer all the questions and provide as much information as possible. Thank you for filling out the form and I look forward to meeting you.

There are 2 sections to this form. Section #1 relates to cannabis use only. Section #2 relates to your entire past medical history. Please answer the following questions related to **cannabis use only.**

Section #1

1. What current disease/diagnosis/condition do you use (or hope to use if you are not currently using) medicinal marijuana for? (Example: Arthritis (not knee pain) Insomnia, (not racing thoughts at night), Multiple Sclerosis (not spasms).

2. What current symptom(s) from the condition listed above do you feel cannabis may help alleviate?

   (Example: Pain relief from arthritis, fatigue due to insomnia, spasm relief from multiple sclerosis. You may list more than one symptom).

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3. List all past and current treatments to treat the symptom(s) above. This includes all prescription medications, any over the counter treatments, herbal treatments, physio, chiro, massage therapy, etc. Please comment on the effectiveness of the treatments and side effects where applicable. (NOTE: Only list the treatments that were used in the past or are currently being used to treat the symptom(s) you are hoping cannabis can alleviate. Do not list all prescriptions which are being used to treat other medical conditions, you will do that in Section #2. Example: DO NOT LIST your blood pressure medications here, as it is not related to why you are seeking cannabis.

Past Treatments	Current Treatments
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____

4. Give an example of how this current symptom affects your daily living. Be as specific as possible. Example: My back pain does not allow me to vacuum the house, do my own cooking, cleaning etc. The drowsiness from my insomnia decreases my work performance the next day.

5. List an example of a daily living chore that you cannot do (or do with extreme difficulty) without cannabis use but can manage to perform if cannabis is used. It can be from the daily living question above. Example: You can vacuum your house with cannabis use but cannot vacuum the house without cannabis use. Note: This is confidential doctor-- patient relationship information, it has ZERO legal implications.

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6. If you have used cannabis, how did the cannabis alleviate your symptom(s) above? List symptom(s) that cannabis is most effective at alleviating?

7. Is Cannabis your most effective medicine at treating the symptom(s) listed above?

8. Has Cannabis helped lower the dose of any other prescription medications? If, yes please list the medications

9. How long have you been using cannabis? Be specific (Example: 5 years, not "a long time", or "since I was a teenager")

10. How many grams a day are you using? Be specific. (Example: 2 grams) If you are unsure of the amount you can write 3 joints, 3 bowl full, etc.

11. How are you using your cannabis? Describe your daily cannabis routine, Example: Vape 1 gram during the day and eat one gram in a brownie at night.

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12. Have you been legally authorized to use cannabis before? If yes, how many grams a day were you authorized to use?

13. Have you experienced any negative side effects from using cannabis?

14. Have you ever taken a break from using cannabis? What happened when you did?

<u>Section #2</u> – This section relates to your entire past medical history

15. Please list any medical conditions (high blood pressure, diabetes, asthma, osteoarthritis, etc)

16. Please list all current medications (except those already listed in section #2)

17. List all allergies to medications

18. List past surgeries

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19. Do you smoke cigarettes? If yes, how long? How many cigarettes per day?

20. How many drinks of alcohol do you have per week?

21. Do you use any illicit drugs?

22. If yes, have you ever had a substance abuse problem?

Thank you for filling out the above form.

Greenleaf Medical Clinic

Dr. M. Hart
Release, Acknowledgement & Indemnity
For Patients Seeking a Medical Cannabis Document

I _____understand that this Release and Acknowledgement contains IMPORTANT information about medical cannabis that the assessing physician requires and 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 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: 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 and
b) My application or prescriptions for possessing, obtaining and using medical cannabis

I am well aware that physician's generally agree that medical cannabis:

- May distort perception) sight, sounds, time, touch)
- 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

INITIAL _____

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 medicinal active cannabis 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 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.

INITIAL_____

In seeking medical cannabis treatment, I confirm I have consulted with a physician 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 said clinic and physicians.

INITIAL_____

This release from liability is to be binding on heirs, executors and signs. I also consent to the disclosure, sharing and use of my personal information and medical data by the assessing physician, and my licensed commercial producer. The information may be used to contract, assess and register the patient and for the 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 I have seen 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 also agree that any legal actions will take place in Ontario and be governed by the laws of Ontario Canada.

PRINT NAME_____

SIGNATURE_____

DATE SIGNED_____

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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.

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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.

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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: _____

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F: 1-604-859-3670
info@GLMC.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)