Medical Cannabis (Marijuana): Intake for Patients and Caregivers

Name: Mark Tino
Date of Birth: 03/12/1956

Phone:_____
Email _____

Certificate Number*:_____

Caregiver's name: _____

Phone:_____ **Email** _____

Primary Care physician: _____

Other clinicians involved in your care:

Name	Specialty	Phone Number

Goals/expectations for visit: What am I looking to achieve during the visit?

- ❑ To learn about the use of cannabis as a treatment option
- ❑ To get a certificate for medical cannabis
- ❑ To get clear diagnosis of my symptoms (Explanation of the symptoms)
- ❑ To consider alternative treatments/ approaches
- ❑ Cannabis tolerability (side effects)
- ❑ Cannabis dosing goals (cannabinoids and opioids)
- ❑ Other_____
  _____
  _____
  _____

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Goal/s for Cannabis use Please write the goals you wish to achieve as a result of utilizing medical cannabis in your medical treatment/management:

- ❑ Pain related (Reduction) _____
- ❑ Cognitive function_____
- ❑ Functional improvement _____
- ❑ Spasm(Reduction in spasticity/muscle spasms)_____
- ❑ Reduction in nausea/vomiting_____
- ❑ Sleep quality _____
- ❑ PTSD symptoms_____
- ❑ General well being (Quality of life)_____
- ❑ Weight gain per week or month _____
- ❑ Behavioral Difficulties_____
- ❑ Other_____

_____

Please list all medical conditions you have been diagnosed with: (The list reflects approved conditions for cannabis use in the state of Pennsylvania)

❑ **Amyotrophic Lateral Sclerosis.**	❑ **Epilepsy.**	❑ **Neuropathies.**
❑ **Autism.**	❑ **Glaucoma.**	❑ **Parkinson's Disease.**
❑ **Cancer.**	❑ **HIV (Human Immunodeficiency Virus) / AIDS (Acquired Immune Deficiency Syndrome).**	❑ **Post-traumatic Stress Disorder.**
❑ **Crohn's Disease.**	❑ **Huntington's Disease.**	❑ **Severe chronic or intractable pain of neuropathic origin or severe chronic or intractable pain in which conventional therapeutic intervention and opiate therapy is contraindicated or ineffective.**
❑ **Damage to the nervous tissue of the spinal cord with objective neurological indication of intractable spasticity.**	❑ **Inflammatory Bowel Disease.**	❑ **Sickle Cell Anemia.**
❑ **Anxiety Disorder**	❑ **Intractable Seizures.**	
	❑ **Multiple Sclerosis.**	

Attestation by patient

I hereby attest that I have discussed the potential of Cannabis to treat my medical condition and reviewed and understand the risks and benefits of the medical use of cannabis (marijuana) with my healthcare practitioner (patient) . I understand some of the risks may include possible long-term effects to the brain in the areas of memory, coordination, and cognition; impairment of the ability to drive or operate heavy machinery; physical or psychological dependence; and respiratory damage if smoked. I understand that I may revoke my designated provider (patient) (if applicable) at any time in writing. I have read and discussed information about/ risks/ potential benefits and side effects and I understand the legal requirements of being a patient.

Warnings:

- ❏ Pregnant or nursing women
- ❏ Potential for dependence and abuse
- ❏ Driving or operating machinery
- ❏ History of psychosis when using psychoactive substances
- ❏ Family History of psychosis

Contraindications:

- ❏ Hypersensitivity to any cannabinoid
- ❏ Past history of psychotic disorder (Paranoia, Hallucinations)
- ❏ Active and unstable cardiovascular disease

Side Effects:

- ❏ Cognitive
- ❏ Balance
- ❏ Other

Patient Signature: _____

Date: _____