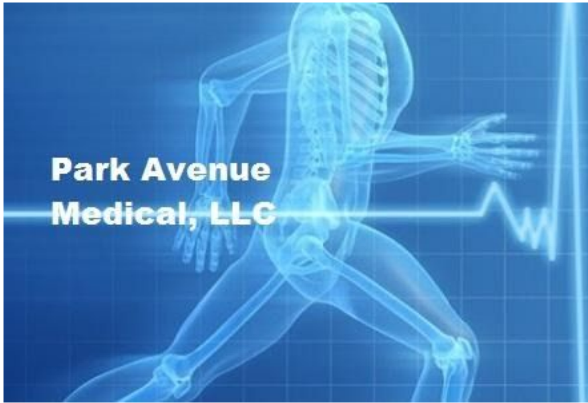
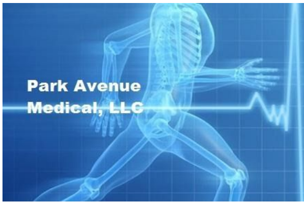


Patient In-take & Consent

Redistribution is strictly forbidden.



Pre-Evaluation Patient Information Questionnaire

Personal Info:

Name: **Date:**

How did you hear about us?

____

____

New Patient? Yes/No Date of birth: Age: ____Height: _____Weight: ______Gender:

Address: City: State: Zip:

Home Phone: Work Phone: Cell Phone:

Email: __________May we email you in the future: Yes / No

Do you have a Facebook or other network site profile? If Yes, what kind:

Are you currently attending school? Yes / No (**if yes**): High School / College / Other

Are you currently working? Yes / No (**if yes)** What is your job?

Are you: Full Time / Part Time / Unemployed / Disabled / Retired / Homemaker / Self Employed

Marital Status: Married / Divorced / Separated / Widowed / Never Married / Other

Do you have children? Yes / No (**if yes,** what are their ages)

(**If female**) Are you currently pregnant? Yes/No

(**If female**) Are you planning on getting pregnant? Yes / No

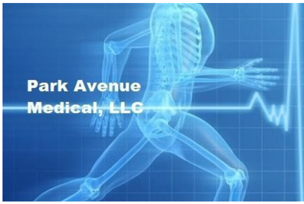
(**If female**) Are you currently breastfeeding? Yes / No

Do you currently have Medical insurance? Yes/No (Circle One): Private / Medicare / Other ________

Have you been arrested or charged with a crime in the past two years? Yes / No

(**If yes**, please describe) ____

____



____

________ ____

Patient Signature: ____ **Date:** _________________

Are you currently on parole or probation? Yes / No (**if yes, please see clinic manager)**

Have you been evaluated for medical marijuana use by another physician in the past? Yes / No

(**If yes,** please give name of practice, doctor, date seen and condition for evaluation) _________________

____ ______________

____

Have you been denied a recommendation for medical marijuana use by another MD in the past? Yes / No

(**If yes,** please explain)

____

____

Are you currently attending or have you attended any substance abuse or rehabilitation program? Yes/No

(**If yes,** please provide details)

____

____

____

Do you ever have thoughts of suicide or have you ever attempted suicide? Yes / No

(**If yes,** please provide details)____

____

____

Medical History:

Did you bring any medical records with you today? Yes / No (**if yes)** What did you bring? _________

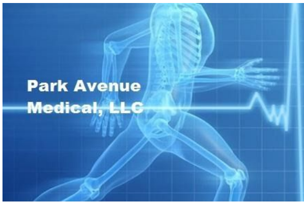
____

____

____

Do you have a primary care physician? Yes / No (**if yes)**

Name: Address: ___Phone: _______



Have you talked to your primary care physician about medical marijuana? Yes / No

Current medical complaint(s): ____

____

__________ __________

Patient Signature: ____ **Date:** ____________________

What prescription drugs do you take currently and what dosages? _______________________________

____

____

Do you currently use tobacco? Yes / No **(if yes)** How often?

____

Do you currently use marijuana? Yes / No **(if yes)** How often and what methods?

____

____

Do you currently drink alcohol? Yes / No **(if yes)** How often?

____

Do you currently use cocaine, methamphetamine, opiates, heroin or other street drugs? Yes / No

(**If yes, explain**)

____

Are you allergic to any medicine? Yes / No (**if yes, list medicine**)

____

Have you ever been hospitalized? Yes / No (**if yes, please provide dates and details**)

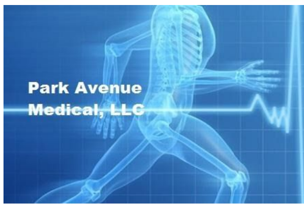
____

Have you ever had surgery? Yes / No (**if yes, please provide dates and details**)

____

Please circle any of the following problems anyone in your immediate family has:
Asthma / Stroke / High Blood Pressure / Cancer / Diabetes / Alcoholism / Hepatitis
Tuberculosis / Substance Abuse / Kidney Disease / Heart Disease / Sinusitis / Other _______

Please circle any of the following problems you have:
Sleeplessness / Chest Pain / Constipation / Nausea / Diarrhea / Loss of Appetite / Stomach Pain



Depression / Vomiting / Anxiety / Rectal Pain / Swollen Ankles / Skin Rash / Palpitations / Headaches Chronic Pain / Muscle Spasm / Difficulty Swallowing / Coughing / Fever / HeartBurn / Seizures / Eye Problems / Blood in Bowels / Other _________

Are there any other health problems that occur frequently with you or your family? Yes / No

Patient Signature: ____ **Date:** ___________________

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 initialing, you understand and agree to the information disclosed. If you have questions or do not understand the information below, consult with the attending physician 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, ______, (Patient's Name)___________(DOB), 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: Cancer, 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:

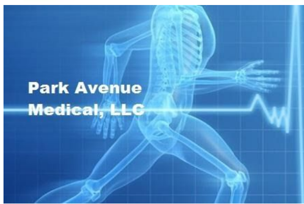
- Substantially limits the ability of the person to conduct one or more major life activities as defined in the Americans with Disabilities Act of 1990 (Public Law 101-336)
- Other conditions for which marijuana provides relief
- If not alleviated, may cause harm to the patient's safety or physical or mental health

Patient agrees by initialing the following:

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 not 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 complex 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, sadness, 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.

I understand that although marijuana does not produce a specific psychosis, the possibility exists that it may exacerbate schizophrenia in persons predisposed to that disorder.

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 a Notice of Compliance has not been issued under the Food and Drug Regulations concerning the safety and effectiveness of Marijuana as a drug. I understand the significance of this fact.

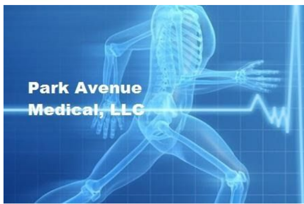
I am aware that medical marijuana has not been approved under Federal Regulations and I understand that medical marijuana has not been deemed legal under federal law.

I understand some users might develop a tolerance to marijuana. This means higher and 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



include, but are not limited to nausea, vomiting, hacking cough, disturbances to heart rhythms, numbness in the limbs, anxiety attacks and incapacitation.

If I start taking medical marijuana, I agree to tell my attending physician if I: Start to feel sad or have crying spells, lose interest in my normal activities, have changes in my normal sleeping patterns, become more irritable than usual, lose my appetite, become unusually tired, withdraw from family and friends, or any other side effect that is not to your liking.

I agree that if I am a female patient that I will contact my attending physician if I become or are thinking about becoming pregnant. I acknowledge that the use of medical marijuana creates pass-through problems to a fetus during pregnancy and to a baby during breastfeeding.

I 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.

I should not be driving a vehicle while using marijuana and that I can get a DUI for driving under the influence.

Medical marijuana is not regulated by the USFDA and therefore may contain unknown quantities of active ingredients, impurities and or contaminants.

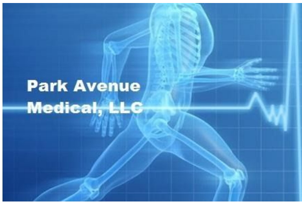
I am not permitted to smoke within 1,000 feet of any daycare or school. If I reside near those institutions, I must use my medicine within the privacy of my own home.

I agree to follow up with the attending physician at Park Avenue Medical LLC with supporting medical records pertaining to my medical conditions.

I understand the attending physician, staff and or representatives of Park Avenue Medical LLC, are neither providing, dispensing nor encouraging me to obtain medical marijuana. I also acknowledge that the attending physician, staff and or representatives of Park Avenue Medical will NOT be providing or discussing information regarding dispensary, co-op, delivery service or any other way to obtain marijuana.

I certify that I have read this document and declare under penalty of perjury that the information contained herein it true, correct and complete. I acknowledge that any manipulation, alteration or falsification of this form, the letter of recommendation will result in the immediate termination of any legal right to my use of medical marijuana. Furthermore, Park Avenue Medical will report any of the above mentioned activities to the appropriate local authorities.

The physician, staff and representatives of Park Avenue Medical LLC, are addressing specific aspects of my medical care and, unless otherwise stated, are in no way establishing themselves as my primary care physician/provider. Furthermore, the undersigned, my heirs, assigns, or anyone else acting on behalf, hold the physician and his/her principals, agents and employees, free of and harmless from any



responsibility for any harm resulting to me and/or other individuals as a result of my medical marijuana use.

_______ I understand that possession of marijuana and cannabis infused products, such as Cannabidiol (CBD) oil, is illegal under federal law. I understand that I have been certified to obtain and use medical marijuana within the State of CT and that traveling across state lines with it can result in criminal charges.

Patient Signature: **Date:**

Release of Liability

I attest that the information on this form is correct and any medical history presented or discussed with the doctor is all factual and complete to the best of my knowledge. I do not plan or intend to use my Physician's recommendation for the purpose of illegally obtaining medical marijuana. Solely for verification purposes, I authorize Park Avenue Medical LLC to converse of my medical condition.

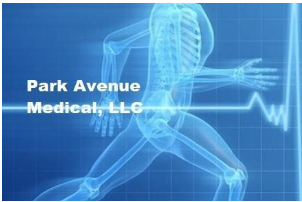
I understand that I must be a Connecticut State resident to obtain an approval or recommendation for the use of medical marijuana under the Connecticut Medical Marijuana Program.

I affirm that I have a serious medical condition that negatively affects my quality of life. I have found or am interested in finding out whether or not medical marijuana provides substantial relief and improvement in my condition.

I understand that the cannabis plant is not regulated by the United States Food and Drug Administration and therefore may contain unknown quantities of active ingredients, impurities and/or contaminants. I understand the potential risks associated with an elevated daily consumption of medical marijuana including risks with respect to the effect on my cardiovascular and pulmonary systems and psychomotor performance, risks associated with the long-term use of marijuana, as well as potential drug dependency. I am aware that 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. In requesting an approval or recommendation for the use of medical marijuana, I assume full responsibility for any and all risks involved in this action.

I have been advised that medical marijuana smoke contains chemicals known as tars that may be harmful to my health. Recent research indicates that vaporizing cannabis may eliminate exposure to tar. Should respiratory problems or other ill effects be experienced in association with its use, it should be discontinued and reported to the physician immediately.

I was also advised that the use of medical marijuana may affect my coordination and cognition in ways that could impair my ability to drive, operate machinery, or engage in potentially hazardous activities. I assume full responsibility for any harm resulting to me and/or other individuals as a result of my use of cannabis.



The State of Connecticut General Assembly – House Bill No. 5389, provides for the possession for the personal medical purposes of the patient with a physician approval or recommendation. It should be made clear that the physician, staff and representatives of this practice are not providing medical marijuana, nor are they encouraging any illegal activity in my obtaining medical marijuana.

I, the undersigned, hereby request a consultation by the physician for purposes of determining the appropriateness of medicinal marijuana treatment. I acknowledge that using cannabis as a medicine has been explained to me and that any questions that I have asked have been answered to my complete satisfaction. The physician, staff, and representatives are addressing specific aspects of my medical care, and unless otherwise stated are in no way establishing themselves as primary care providers. Should an approval be made for my medicinal use of marijuana, I understand that there is a renewal date specified by the physician depending on the condition. I understand that it is my responsibility to see the physician to assess the possible continuance of cannabis use beyond the term of the approval.

Furthermore, the undersigned, or anyone acting on my behalf, hold the physician and his/her principals, agents, and employees, free of and harmless from any liability resulting from the use of medical marijuana.

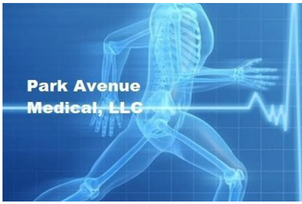
I further understand that by signing below, I am authorizing the release of any part of this record, except for identifying information, for use in data analysis of medical marijuana treated patients.

Patient Signature: **Date:**

Medical Marijuana Patient Declaration

I hereby declare that I have completely and truthfully disclosed all information regarding my medical condition and attest that I do not intend to use my medical recommendation for the purpose of illegally obtaining, growing or distributing medical marijuana. I attest that I am not a member, employee or agent of any media or law enforcement agency. It is illegal to film or record in this office with a video camera, cell phone or any other recording device be it a still image, video or audio. This is a direct violation of HIPAA regulations and patient/doctor confidentiality. I am aware that my recommendation can be revoked at any time and legal actions will be taken if I have perjured or misrepresented myself or my condition, my intentions or falsified any medical records to the physician. I also hereby authorize MarijuanaDoctors, or its representative to discuss my medical condition for verification purposes only.

Additionally, I acknowledge the attending physician informed me of the nature of a recommended treatment, including but not limited to, any recommendation regarding medical marijuana. The risks, complications and expected benefits of any recommended treatment, including its likelihood of success and failure. I acknowledge the attending physician informed me of any alternatives to the recommended treatment, including the alternative of no treatment, and their risks and benefits. The physician may



request that I visit another physician or specialist to further substantiate my condition. I will be informed of all the above mentioned regardless of whether or not I qualify as a patient.

Patient Name (Print): Telephone Number:

Patient Signature: Alt. Phone Number:

Current Address: City State ___Zip ______

The attending physician will fully explain to me the nature and purpose of medical marijuana treatment, including its benefits and possible side effects.

HIPAA Notice of Privacy Practices Acknowledgement of Receipt

By signing this, I hereby acknowledge that I have read and understand the privacy practice notice and may obtain additional copies upon my request. This acknowledgement will be filed with my records.

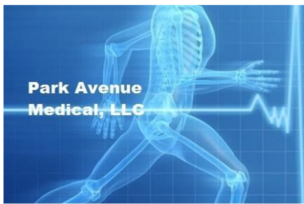
Authorization for Release of Confidential Records

I, , Date of Birth, , hereby authorize Marijuana Doctors to disclose and verify me as a patient to any law enforcement agency, my physician(s), Child Protective Services or any state approved Connecticut dispensary. This is valid during the period of time for which the recommendation has been issued. This consent is subject to written revocation only, at any time except to the extent that action has already been taken on the basis of this consent.

I give permission for my medical records and file to be reviewed by another physician working with Marijuana Doctors. I understand that this might happen if the original doctor that evaluated me needs a secondary opinion, is not available, off premise, has moved or terminated his/her practice.

DO NOT SIGN BELOW THIS LINE

I have asked the patient if he/she has any questions regarding his/her treatment with medical marijuana. I have answered those questions to the best of my ability.



Physician Signature: **Date:**

Authorization for Park Avenue Medical LLC, to complete the Application with the State of CT

_____ I authorize Park Avenue Medical LLC, and its staff members to complete my application with the State of CT in order for me to obtain my Medical Marijuana Certification. I authorize them to assist me in creating my BIZ NET account, upload required documentation and submit payment of **$100.00 with the credit/debit card I have provided them**.

_________________________________ _________________________________

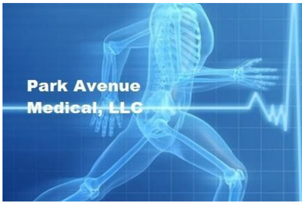
(Print Name) (Signature)

Forms of Identity Accepted by DCP

- CT or Out-of-State Issued Driver's License (Must be Current)
- CT Issued Identification Card
- CT Pistol or Firearms Permit
- US Passport or Passport Card
- Permanent Resident Card
- Certificate of Naturalization
- Certificate of Citizenship

Acceptable Documents for Proof of Residency

- Computer-generated bill or statement from a bank or mortgage company, utility company , doctor or hospital
- Pre-printed pay stub showing BOTH your name and address and your employer's name and address
- W-2 form, property or excise tax bill, or Social Security Administration or other pension or retirement annual benefits summary statement and dated within the current or prior year.
- Medicaid or Medicare benefit statement
- Current valid homeowner's, renters or motor vehicle insurance policy dated within the last year
- Current motor vehicle loan statement for a motor vehicle registered in your name



- Residential mortgage or similar loan contract, lease or rental contract showing signatures from all parties needed to execute the agreement and dated within the last year
- First Class mail addresses to your home address
- CT voter registration card
- CT handgun permit
- Motor Vehicle Registration

We do need all of the required documentation in order to complete your State o CT application the same day of your appointment.

Please read the following statements. These are the certifications that the CT Department of Consumer Protection (DCP) requires you to answer when completing your application with the State of CT. The purpose of you answering the questions is so we can do so on your behalf when completing your application in the office. Please circle YES or NO after each statement.

I understand that I will not qualify for a medical marijuana registration certificate if I am confined in a correctional institution or facility under the supervision of The Department of Corrections. I hereby give The Department of Consumer Protection permission to confirm my status with The Department of Corrections.

YES OR NO

I understand that if my physician has indicated the need for me to have a primary caregiver, (someone who can accompany me to the dispensary or go on my behalf) my application will not be approved until the primary caregiver completes their registration application and that application is approved.

YES OR NO

I understand that if there are any changes to the information provided on this application, I must notify the Department of Consumer Protection within 5 Business Days of such change.

YES OR NO

I understand that any marijuana I acquire is for my use only and that I risk having my registration revoked if I sell, share or otherwise provide my marijuana to any other person.

YES OR NO