SWEET GRASS WELLNESS CLINIC

Our Process

Complete the application forms included in this package, you may fax it to 416-907-1774 or scan the completed application package and email it back to info@sgwellness.ca . You must include with this package: Any supporting medical documents (prescription history print out, medical imaging reports, doctors note identifying your medical condition), AND a clear copy of valid picture ID (Health Card, Driver's License, Passport ONLY).

While your application is under review for eligibility, we will discuss which Licensed Producer choices are best suited for your needs and assist you in the registration process so you can be ready to purchase your medical cannabis as soon as possible as it can take up to 72 hrs.

Once our have submitted your application, please allow up to 48hrs for processing time. Once your application is approved, the date and time of your consultation will be communicated to you via email or telephone, so please ensure this contact information is written clearly on your application. Consultations are less than 30 mins via telemedicine (i.e. Sylo, FaceTime, Skype)

After the consultation with the Nurse Practitioner, they will sign the required medical document and send it to the LP that you have chosen. You will then officially become a legally authorized medical cannabis patient in Canada!

We require 100% of the consultation package fee, immediately after your consultation is completed with the Nurse Practitioner. Once received your medical document will be mailed out via express post after payment is received; a tracking number will be sent to you so you can keep track until you receive it.

If you are a patient who will be producing your own medication, we offer additional assistance with the completion of the paperwork required by Health Canada. Please be advised you are not permitted to start growing until after Health Canada has approved your application for production.

If you have any questions or concerns, you may contact us at any time. Thank you once again for choosing Sweet Grass Wellness Clinic to get licensed.

Release, Acknowledgment & Indemnity

For Patients seeking an ACMPR Medical Document

I, _____, understand that this Release and Acknowledgement contains valuable information about possessing/cultivating and consuming prescribed medical cannabis and that the assessing Physician/Nurse Practitioner requires it to issue a medical document for the Access to Cannabis for Medical Purposes Regulations (ACMPR). I also understand that the consulting Physician/Nurse Practitioner will not be assuming primary care for me, but will only be recognized as my ACMPR prescribing Practitioner. I understand and agree to continue to regularly see my primary care Physician for my medical conditions on a regular basis and notify them of my medical use of cannabis. Initials _____

I, _____ confirm that the assessing Specialist/Nurse Practitioner will be the only practitioner providing a medical document under the ACMPR for the purpose of possessing/cultivating and consuming medical cannabis. Initials _____

I, _____ agree to make no claims or commence any legal action against Sweet Grass Wellness: Kamania Parris, the assessing Nurse Practitioner, my family Physician, or cannabis educators:

i) My consumption of medical cannabis
ii) My Application or medical document(s) for possessing, obtaining, cultivating and consuming medical cannabis

Initials _____

I, am aware that Physicians/Nurse Practitioners generally agree that medical cannabis:

-May affect sight, sounds and touch

-May impair thinking, problem-solving, coordination, memory and learning

-May increase heart rate and decrease blood pressure

-May induce anxiety, panic, fear, distrust Initials _____

I am aware that a medical history that includes conditions such as Schizophrenia, Atrial fibrillation, Heart attack or Stroke or daily use of blood thinners may result in a denial for my application to possess and consume medical cannabis. I am also aware that if pregnant, or planning to become pregnant, that medical cannabis should not be consumed during pregnancy or while breastfeeding. Initials _____

I, understand that cannabis is not an approved therapeutic drug in Canada and that there is a lack of consensus amongst Physicians/Specialists on:

-The appropriate dose and medical use of cannabis
-The risks of burning medical cannabis as compared to vaporizing or ingesting
-The risks of burning extracted cannabinoids such as oils or hashish
- The risk of pulmonary infections and respiratory cancer
- The long term psychological and health risks associated with medical cannabis
-The risk of triggering mental illness, such as bipolar disorder and schizophrenia
-The risk of nausea and disorientation *Initials _____*

I, _____, truly believe that treating my personal medical condition(s) with medical cannabis, can potentially, or has had, a positive effect and the benefits outweigh the risks associated with previous methods used & this is my personal decision to possess and consume medical cannabis.

Initials _____

I, _____, consent to the disclosure, sharing and use of my personal health information by the assessing Nurse Practitioner associated with Sweet Grass Wellness, my Licensed Producer or Health Canada for the process of obtaining my Medical Document. The information will be used to contact and register as a patient.

Initials _____

I am aware If you drive a vehicle on the road or operate machinery, do NOT do so:

1. Within 4 (FOUR) hours of inhaling cannabis vapor or smoke,
2. Within 6 (SIX) hours of eating or ingesting cannabis edibles or oil,
3. Within 8 (EIGHT) hours of using, if you get euphoric or dizzy - "Stoned" Initials _____

I hereby release Sweet Grass Wellness, the assessing Nurse Practitioner, his/her clinic, my family Physician and any other involved Physicians/parties 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 and my application to possess and/or produce medical cannabis.

******Remember to keep all cannabis products, and medicines, in a Locked Box.***

Patient Name: _____ *Witness Name:* _____

Signature: _____ *Witness Signature:* _____

Date Signed (D/M/Y): _____ *Date Signed (D/M/Y):* _____

CONSENT FOR TREATMENT

Preamble:

It is understood and has always been understood by me that all physicians/NPs have an obligation to use their skill and expertise in deciphering the reasonable care and treatment for patients regardless of their medical condition. This obligation is not different in relation to Marijuana Treatment and the patient understands this principal.

Sections:

1. I agree to consider and be guided by the treatment plan and recommendations of my healthcare practitioner who is supervising my care in relation to the use of marijuana.
2. I understand and agree in keeping with the above noted provision (section 1) to consume only amounts/doses authorized and prescribe for me by my health care practitioner and therefore I agree not to consume any amount over and above that which has been prescribed for me.
3. I am aware that it is my obligation and responsibility to advise immediately the health care practitioner of any possibly perceived side effects of the product.
4. It is very important to understand and I do understand the importance and necessity to desist and abstain absolutely from using illegal/street drugs (Cocaine-powder or crack, heroine, Meth) or controlled substances such as morphine, narcotics, stimulants or anxiety pills not prescribed currently during the course of my marijuana treatment.
5. In keeping with the above noted understanding in Section 4, I undertake to and shall advise my healthcare practitioner if I am presently at the time of my marijuana use authorization, I have been using a prescribed controlled substance by another doctor.
6. I do understand, accept and agree that my Nurse Practitioner may exercise the option to discontinue authorizing marijuana for my use temporarily until further notice if an assessment reveals that the medical risks or side effects manifested during the course of my treatment are so significant that they (risks and side effects) out-weigh the beneficial result from such use.
7. I recognize the importance and do agree to see any medical specialist or therapist to who I may be referred by my NP in relation to my medical condition.
8. It is understood that I have on my own volition chosen and decided to pursue the procedure requirements to obtain the use of marijuana for my medical condition. As such, I take full responsibility for risks associated with the use of marijuana and side effects I may experience. This section must be read together with section 4.

Access:

9. I understand that there is a legal requirement for me to obtain my marijuana from an authorized Licensed Producer or I may register with Health Canada to grow my own perhanps someone else grow it for me.

Patient Name Printed: _____ Patient Signature: _____

Date: _____

CONSENT TO USE ELECTRONIC COMMUNICATIONS

NURSE PRACTITIONER INFORMATION

Nurse Practitioner Name:	Kamania Parris
Address:	10 FOUR SEASONS PLACE STE #1000, TORONTO, ON, M9B 6H7
Email:	INFO @ SGWELLNESS. CA
Phone: (as required for Medical Service(s)	647-877-8180

The Patient has agreed to communicate for consultations with the Ontario Licensed Nurse Practitioner using any of the following means of electronic communication:

- ☐ *Email (specify):*
- ☐ *Text messaging (including instant messaging):*
- ☐ *Videoconferencing (including: FaceTime / Skype / Sylo / /WhatsApp): (circle preference)*
- ☐ *Other (specify): Telephone calls*

PATIENT ACKNOWLEDGMENT AND AGREEMENT:

I acknowledge that I am actively aware of the risk implicit and explicit, of the above noted electronic communication tools.

I understand the substantial risks of electronic communication generally and particularly of electronic mail (e-mail, text messaging) in that they can be intercepted by third parties or can be sent in error to third parties other than for whom such communication was meant i.e. the intending recipient.

It is understood that my consent to use the above noted electronic communication tools is presumed on the written understanding that the Nurse Practitioner will employ the best possible protective methods to secure the safety and integrity of the communication made during and after the consultation. Reciprocally the patient will ensure that the device he/she uses is equipped with protective means thereby enhancing the integrity and confidentiality of the communication.

Both the Nurse Practitioner and I agree that each may at any time, upon informing the other in writing, of his/her withdrawal from using electronic communication for consultations.

Patient First and Last Name:	
Patient Complete Address:	
Patient Phone Number:	Patient Email:
Video Conference Platform- Address:	

Patient Signature: _____ **Date: (D/M/Y)** _____

Patient Information

First name and Surname: _____

Address: _____

City: _____ Postal Code: _____ DOB (D/M/Y): _____

Phone: _____ Email: _____

Gender (circle): M F Preferred method(s) of contact (circle): Phone Video

Time of day best to book your appointment: ☐ 9am-Noon ☐ 1pm--4pm ☐ 5pm-9pm (your local time)

Are you a Veteran? Yes ☐ *Will you be producing your own medicine?* Yes ☐

Referred By: _____ Dosage Requested: _____

PRIMARY CONCERNS

What symptoms apply to your current medical condition(s)?

***Please check all the boxes related to what you experience due to your medical condition(s)**

	Abdominal Pain		Fatigue		Muscle Spasms
	Diarrhea		Foot Pain		Nausea
	Difficulty Eating		Difficulty Sleeping		Involuntary movements
	Constipation		Headaches		Seizures
	Chronic Pain		Hip Pain		Vision Issues
	Back Pain		Low Energy		Weakness
	Depression		Menstrual Pains		Blood clots
	Anxiety		Mobility Issues		Weight Loss

Medical History

- *Do you have a primary care physician(circle)? Yes No*
  (If yes, please provide details below) (If, No, please list the information of the health facility you use)

  Name:_____Address:_____Phone_____

- *Have you talked to your primary care physician about medical marijuana (circle)? Yes*

Current medical conditions OR pending health investigation(s):_____

_____

Height: _____(cm) Weight: _____(lbs) Waist/Pant size: _____

Client Initials: _____

Current Prescription Medications &/or Supplements/Herb(s): -

_____

_____

_____

Chief Problem(s) for which Cannabis is being requested: _____

- *Do you have any diagnostic imaging reports (i.e. x-rays, ultrasound, MRI,) or hospital visits to support your medical condition(s) reported? Yes No*

- *Have you been denied a prescription for medical marijuana use by another MD in the past (circle)?*
  Yes No

*(if yes, please explain*_____

What year did the medical problems start? _____*(year)*

What makes the problem worse? _____

Activities of Daily Living Assessment:

Please check if any of the following activities are substantially limited ***(i.e. pain/weakness/impaired strength or ability)*** *by the medical condition for which you seek medical marijuana certification?*

___ *caring for myself*
___ *performing manual tasks*
___ *hearing*
___ *eating*
___ *seeing*
___ *bending*
___ *standing*
___ *sleeping*
___ *learning*
___ *speaking*
___ *other (please specify below)*

___ *lifting*
___ *thinking*
___ *reading*
___ *breathing*
___ *social interaction*
___ *communicating*
___ *concentrating*
___ *operation of major bodily function*
___ *working*

_____

_____

Client Signature: _____ *Date:* _____

Medical Cannabis Research Questionnaire

Please carefully read each question and circle answers where indicated

- *How long have you been consuming medical Cannabis for? (Circle One)*
  A. Never- New Patient B. 1 Year or less C. 2-5 Years D. 6-10 Years E. 11-20 Years F. 21+ Years

- *Does marijuana provide relief for your symptoms (if yes, please describe, e.g. Decreases pain, improves sleep, etc.): _____*
  _____

- *How effective is marijuana in treating the symptoms of your condition? (circle one)*
  Very effective B. Effective C. Somewhat effective

- *How long have you been consuming cannabis? (circle one)*
  A. 1 year or less B. 2-5 Years C. 6-10 Years D. 11-20 Years E. 21+ Years

- *Frequency of marijuana use as a medicine? (Circle one)*
  A. Daily B. Weekly C. monthly

- *What is the <u>most common</u> way that you consume medical Cannabis? (circle one)*
  A. Smoking B. Vaporizing C. Edibles D. Oils E. Creams F. Concentrates G. Other

- *How much Cannabis do you consume on a daily basis? (circle one)*

  A. Less than 1 Gram B. 1 Gram C. 2 Grams D. 3-5 Grams E. 6-10 Grams F. 11 Grams or more

- *What is the main reason why you consume Cannabis? (circle one)*
  A. Pain Management B. Relaxation C. Appetite D. Energy E. Symptom Management F. Other
  If Other, please specify: _____

- *Do you prefer consuming Sativa or Indica strains? (circle one)*
  A. Sativa B. Indica C. Both
- *Please list any medications you have taken in the past that failed to give you relief?*

  _____
  _____

- *Does use of marijuana modify your use of any other drugs or medications (circle)? Yes No*

  If yes, what dosage? Please Explain:
  _____
  _____

- *Does use of marijuana modify your use of alcohol (circle)? Yes No Intials _____*

Please Explain:

_____

_____

- *You understand that smoking is harmful to your lungs and is not medically advised (circle)? Yes No*
- *Have you had any negative/adverse reaction from use of marijuana? Yes No*

If yes, please describe:

_____

Medical Cannabis Assessment

- Have you been hospitalized for any of the conditions reported? Yes No
- If Yes above, how many times a day do you use it? _____
- How long have you used it medically? _____
- If you do not obtain a prescription for marijuana, will you continue to use it? Yes No

- Do you smoke tobacco? No Yes- (cigarettes, cigars, pipe) Number per day _____
- Do you use medicines containing opiates? (Codeine, Morphine, Dilaudid, other) Yes, No
  If yes, please list name, dosage and how often you take them _____
  _____

- Have you been denied a prescription for medical marijuana use by another MD in the past? Yes No
  (if yes, please explain_____

CAGE QUESTIONNAIRE

1. Have you ever felt you should cut down on your drinking? Yes No
2. Have people annoyed you by criticizing your drinking? Yes No
3. Have you ever felt bad or guilty about drinking? Yes No
4. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (eye-opener)? Yes No

Psychological History: (please circle applicable diagnosis below)

- Do you suffer from: Anxiety Depressions Insomnia Bipolar Disorder OCD
- What year did the condition begin? _____
- Have you been hospitalized for any of these? No Yes (If yes, what year) _____
- Have you had any thoughts of self-harm or suicide? No Yes

- *Are you currently attending or have you attended any substance abuse or rehabilitation program (circle)?*
  Yes No
  If yes, provide details: _____

Social History: (Please circle what applies)

- Are you: Single Married Common law Divorced Other
- Do you reside in a House Apartment Shared space Institution No fixed address
- Who lives with you? Wife, Husband, partner, children, no one

If children are in the home, please list their ages: _____

Family History

Is your father alive? No Yes In good health? If no- Cause of death_____

Is your mother alive? No Yes In good health? If no- Cause of death _____

Do you have siblings? No Yes Please list ages, genders and states of health

Do any of your family memebers suffer from psychiatric disorders? No Yes

If Yes, which family member and what condition(s)? _____

Review of Systems

Do you have any problems with your senses (smell, taste, sight, hearing or touch)? No Yes

Do you have any problems with your head or neck? No Yes

Do you have any problems with breathing or lung diseases? No Yes

Do you have heart or circulation problems? No Yes

Have you ever had a heart attack? No Yes

DO you have any eating, swallowing, digestion or problems with bowels? No Yes

Do you have any problems with your kidneys, bladder or urination? No Yes

Are you pregnant now or might you become pregnant in the near future? No Yes

Do you have problems with your muscles or joints? No Yes

Do you have any swelling anywhere? No Yes

Please explain any "Yes" answers: _____

_____

_____

Do you have any other questions for the Nurse Practtioner that you would like to discuss during your consultation?

Please list below:

Patient Signature: _____ *Date:* _____

CONSENT FOR RELEASE OF MEDICAL INFORMATION

PHYSICIAN INFORMATION

Physician Name: Phone # : Fax # :

_____ _____ _____

PATIENT INFORMATION

Mr/Mrs Last Name:_____ Gender: M F

Ms/Mrs First Name: _____

Date of Birth (M/D/Y): _____ Provincial Health Card: _____

Address:

City: _____Province: _____ Postal Code: _____

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

PATIENT MEDICAL HISTORY

Please provide documentation pertaining to the following medical condition(s):

_____

_____

_____

Please note

Our Nurse Practitioner 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:* _____

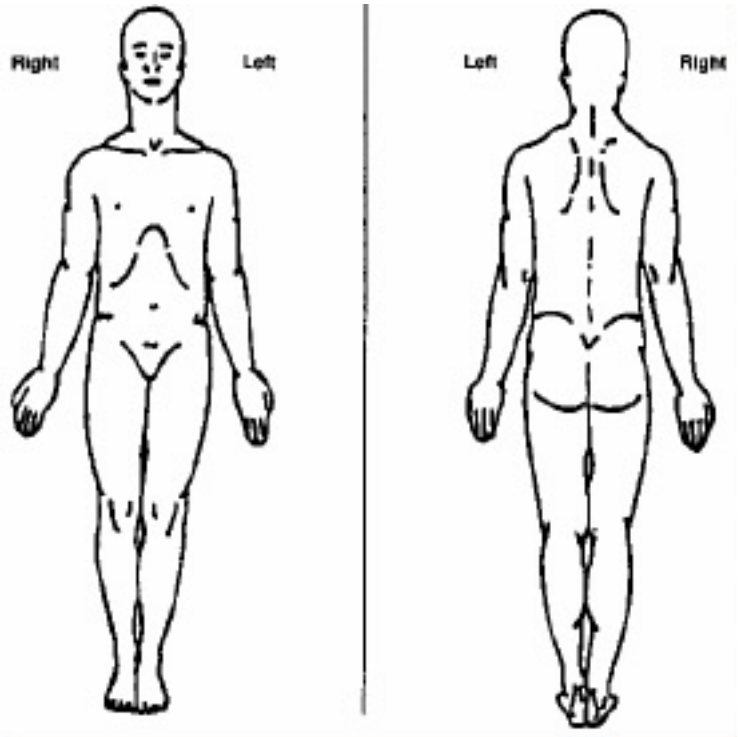
Brief Pain Inventory

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? (circle)

Yes No

2. On the diagram, shade in the areas where you feel pain. ***Put an X on the area(s) that hurts the most****.*

Front *Back*



3*. Please rate your pain by circling 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 at the worst you can imagine*

4. *Please rate your pain by circling 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

5*. Please rate your pain by circling the number that best describes your pain on the* ***average****.*

0 1 2 3 4 5 6 7 8 9 10

6. *Please rate your pain by circling the number that tells how much pain you have* ***right now***

0 1 2 3 4 5 6 7 8 9 10

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 circle the percentage that most shows how much relief.*

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
No Relief										Complete Relief

9. *Fill in the number that best describes how, during the past 24 hours, pain has interfered with your:*

A ***General Acitivity:***

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

B ***Mood:***

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

C ***Walking Ability:***

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

D ***Normal Work (Includes both work outside the home and housework):***

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

E ***Relations with other people:***

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

F ***Sleep:***

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

G ***Enjoyment of life:***

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

Anxiety and Depression Scale

*Tick the box beside the reply that is closest to how you have been **feeling in the past week.***

Don't take too long over your replies: your immediate is best.

D	A	I feel tense or 'wound up':	D	A	I feel as if I am slowed down:
	3	Most of the time	3		Nearly all the time
	2	A lot of the time	2		Very often
	1	From time to time, occasionally	1		Sometimes
	0	Not at all	0		Not at all
		I still enjoy the things I used to enjoy:			**I get a sort of frightened feeling like 'butterflies' in the stomach:**
0		Definitely as much		0	Not at all
1		Not quite so much		1	Occasionally
2		Only a little		2	Quite Often
3		Hardly at all		3	Very Often
		I get a frightened feeling as if something awful is about to happen:			**I have lost interest in my appearance:**
	3	Very definitely, quite badly	3		Definitely
	2	Yes, but not too badly	2		I don't take as much care as I should
	1	A little but it doesn't worry me	1		I may not take quite as much care
	0	Not at all	0		I take just as much care as ever
		I can laugh and see the funny side of things:			**I feel restless as I have to be on the move:**
0		As much as I always could		3	Very much indeed
1		Not quite so much now		2	Quite a lot
2		Definitely not so much now		1	Not very much
3		Not at all		0	Not at all
		Worrying thoughts go through my mind:			**I look forward with enjoyment to things:**
	3	A great deal of the time	0		As much as I ever did
	2	A lot of the time	1		Rather less than I used to
	1	From time to time, but not too often	2		Definitely less than I used to
	0	Only occasionally	3		Hardly at all
		I feel cheerful:			**I get sudden feelings of panic:**
3		Not at all		3	Very often indeed
2		Not often		2	Quite often
1		Sometimes		1	Not very often
0		Most of the time		0	Not at all
		I can sit at ease and feel relaxed:			**I can enjoy a good book or radio or TV program:**
	0	Definitely	0		Often
	1	Usually	1		Sometimes
	2	Not often	2		Not Often
	3	Not at all	3		Very Seldom

Additional Consult Notes:

OPIOID RISK TOOL FORM			
PATIENT NAME:			
DATE:			
		Mark Each Box That Applies	
		Item Score If Female	Item Score If Male
Family History of Substance Abuse	• Alcohol • Illegal Drugs • Prescription Drugs	1 ☐ 2 ☐ 4 ☐	3 ☐ 3 ☐ 4 ☐
Personal History of Substance Abuse	• Alcohol • Illegal Drugs • Prescription Drugs	3 ☐ 4 ☐ 5 ☐	3 ☐ 4 ☐ 5 ☐
Age (Mark Box if you are 16-45 yrs of age)		1 ☐	1 ☐
History of Preadolescent Sexual Abuse		3 ☐	0 ☐
Psychological Disorder	• Attention Deficit Disorder • Obsessive Compulsive • BiPolar/Manic Depressive • Schizophrenia • Depression	2 ☐ 1 ☐	2 ☐ 1 ☐
Total Score (Add your columns scores) =			

Total Score Risk Category	
Low Risk	0-3
Moderate Risk	4-7
High Risk	> 7