MEDICAL CANNABIS EVALUATION FORM

Primary Condition: _____

Symptom: _____ Frequency: _____ Times Per: DAY WEEK MONTH YEAR

Symptom: _____ Frequency: _____ Times Per: DAY WEEK MONTH YEAR

Secondary Condition: _____

Symptom: _____ Frequency: _____ Times Per: DAY WEEK MONTH YEAR

Symptom: _____ Frequency: _____ Times Per: DAY WEEK MONTH YEAR

Prior Treatment: _____

Duration of Treatment: _____ Outcome of Treatment: _____

Prior Treatment: _____

Duration of Treatment: _____ Outcome of Treatment: _____

Prescription Medication: _____

Regimen/Dosage: _____ Target Symptom: _____

Prescription Medication: _____ Dosage: _____

Regimen: _____ Target Symptom: _____

Prescription Medication: _____ Dosage: _____

Regimen: _____ Target Symptom: _____

Vitamins/Supplements/Herbals: _____

Regimen/Dosage: _____ Target Symptom: _____

Vitamins/Supplements/Herbals: _____

Regimen/Dosage: _____ Target Symptom: _____

Are you currently taking Aspirin, Coumadin, Clavix, Persantine, or other blood thinners? YES NO

Do you currently use cannabis/marijuana? YES NO

If yes, how often do you use cannabis/marijuana? _____

By what methods do you use cannabis/marijuana? (smoking, vaping oils, edibles, topical ointments)

_____

Does cannabis/marijuana alleviate the symptoms associated with your health issues? YES NO

Patient Acknowledgements, Agreements, Disclosures, and Informed Consent

I, _____, (Patient's Name), understand that medical cannabis/marijuana is a medicine used in treating the suffering caused by serious and debilitating medical conditions. Serious and debilitating medical conditions include: cancer, HIV/AIDS, epilepsy, Multiple Sclerosis, Parkinson's Disease, ALS (Lou Gehrig's Disease), damage to the nervous tissue of the spinal cord with objective neurological indication of intractable spasticity (any spinal cord injury), Inflammatory Bowel Disease, Huntington's Disease, any type of neuropathy; any condition that is severe, for which other medical treatments have been ineffective, and if the symptoms from such condition "reasonably can be expected to be relieved" by the use of medical cannabis/marijuana. Additionally, medical cannabis/marijuana is used in the treatment of other chronic or persistent medical symptoms that:

- Substantially limit the ability of a person to perform one or more major life activities as defined by the Americans with Disabilities Act of 1990 (Public Law 101-336)
- If not alleviated may cause harm to the patient's safety or physical or mental health
- Cause severe loss of appetite, severe or chronic pain, severe nausea, seizures, severe or persistent muscle spasms, glaucoma, or post traumatic stress disorder (PTSD)

Driving; Use of Machinery; DUI. I have been advised that the use of medical cannabis may affect my coordination, motor skills, or cognition in ways that could impair my ability to drive or operate heavy machinery. I hereby agree not to drive, operate heavy machinery, or engage in potentially hazardous activities while under the influence of medical cannabis. I further understand that I should not be driving a vehicle while under the influence of cannabis. I acknowledge and understand that I can get a DUI for driving under the influence of cannabis.

Side Effects Associated with Cannabis Use. I understand that side effects may occur while I am taking medical cannabis. Side effects of medical cannabis may 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, and increased appetite or eating.

Dependency and Withdrawal. I understand that some patients may become dependent on cannabis. This means that some patients experience withdrawal symptoms when they stop using cannabis. Signs of withdrawal symptoms may include, but are not limited to: 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 cannabis may lead to bronchitis and general apathy. I also understand that although cannabis does not produce any specific psychosis, cannabis may exacerbate schizophrenia in people predisposed to such a disorder.

Cannabis Use In Conjunction with Medications. I agree to inform the Greenhouse Integrative Medicine, LLC if I ever: have symptoms of depression, been psychotic, attempted suicide or desire to attempt suicide, or had or have any other mental problems and/or related illnesses. I also agree to inform Greenhouse Integrative Medicine, LLC if I have ever been prescribed or taken medicine for any of the conditions stated above. Furthermore, I understand that Greenhouse Integrative Medicine, LLC does not suggest nor condone that I cease treatment and or medication that stabilize my mental or physical condition(s).

Herbs. I understand there are few known interactions between medical cannabis and medications, other than herbs. However, very few interactions between herbs and medications have been researched and studied. I agree to inform Greenhouse Integrative Medicine, LLC if I am using any herbs, supplements, and/or other medications.

Cannabis Tolerance. I understand some cannabis users may develop a tolerance to cannabis, which in turn may require some cannabis users to take higher doses of cannabis to achieve the same medicinal benefit. I agree to consult with my treating physician at Greenhouse Integrative Medicine, LLC if I develop a tolerance to cannabis, for which a higher dose may be recommended and/or prescribed.

Unknown Risks Associated with Cannabis Use. I understand the benefits and risks associated with the use of cannabis are not comprehensive, and that the use of cannabis may involve risks that have not been identified, thoroughly researched, and/or completely studied and examined. I understand such risks, and I knowingly and voluntarily accept such risks.

Potential Problems and Related Illnesses. I acknowledge and understand that respiratory problems or other illnesses could be potential side effects in association with the use of medical cannabis. I understand the potential risks associated with an elevated daily consumption of medical cannabis including, without limitation, risks with respect to the effect(s) on my cardiovascular and pulmonary systems; risks with respect to psychomotor performance; risks associated with the long-term use of cannabis; as well as risks associated with potential drug dependency. I agree to discontinue the use of cannabis and to report any such problems, illnesses, or side effects to Greenhouse Integrative Medicine, LLC if such problems, illnesses, or side effects should occur.

Risks Associated with Smoking Cannabis. Although smoking cannabis has not been linked to lung cancer, smoking cannabis can cause respiratory harm, such as bronchitis. Many researchers agree that cannabis smoke contains known carcinogens (chemicals that can cause cancer) and that smoking cannabis may increase the risk of respiratory diseases and cancers in the lungs, mouth, and tongue. I have been advised that medical cannabis smoke contains chemicals (known as tars) that may be harmful to my health.

Permitted Forms of Cannabis Use. I understand that there are many methods of intake that substantially reduce the harmful effects of smoking cannabis such as vaporizers, edibles, tinctures, oils, pills, gels, creams, ointments, etc. I further acknowledge and understand that the Pennsylvania Medical Marijuana Act allows for the intake of cannabis through the following forms only: pill; oil; topical forms (including gels, creams, or ointments); a form medically appropriate for administration by vaporization or nebulization (excluding dry leaf or plant form until dried leaf or plant forms become acceptable under regulations adopted under Section 1202); tincture; or liquid.

Prohibited Forms of Cannabis Use. I also acknowledge and understand that the Pennsylvania Medical Marijuana Act prohibits the smoking of cannabis in dry leaf form, but allows for the vaporization of cannabis. However, following the issuance of the Medical Marijuana Advisory Board's report, the Department of Health of the Commonwealth could promulgate a rule that would allow patient access to dry leaf cannabis, from which smoking may be permitted. Currently, I understand that no such rule or law exists.

Unlawful Use of Medical Cannabis. I acknowledge and understand that it is unlawful to: smoke medical cannabis; incorporate medical cannabis into edible form (unless cannabis is incorporated into edible form by a patient or caregiver for the sole purpose of aiding ingestion of medical cannabis by the patient); grow medical cannabis unless the grower/processor has received a permit from the Department of Health of the Commonwealth under the Pennsylvania Medical Marijuana Act; or dispense medical cannabis unless the dispensary has received a permit from the Department of Health of the Commonwealth under the Pennsylvania Medical Marijuana Act.

Potency; Overdose. I acknowledge and understand that cannabis varies in potency. The effects of cannabis may also vary, depending on the delivery method. Estimating the proper cannabis dosage is very important. Symptoms of cannabis overdose include, but are not limited to, nausea, vomiting, hacking cough, heart rhythm disturbances, numbness in the limbs, anxiety attacks, and/or incapacitation.

Notification of Mental and/or Physical Side Effects. If I start using medical cannabis, I agree to inform Greenhouse Integrative Medicine, LLC if and when any of the following events occur: prolonged sadness or crying spells; loss of interest in normal activities; changes to my normal sleeping patterns; prolonged or unusual irritability; loss of appetite; unusual or prolonged tiredness; withdraw from family and friends; or any other side effect that is unusual, negative, destructive, or harmful to my mental or physical health.

Pregnancy; Breastfeeding; Female Patients. I agree that if I am a female patient, and I become pregnant, plan on getting pregnant, or consider becoming pregnant in the near future, that I shall disclose such pregnancy, plans, or considerations to Greenhouse Integrative Medicine, LLC. I acknowledge that the use of medical cannabis causes and/or creates pass-through problems to a fetus during pregnancy, and to a baby while breastfeeding. I agree that I will not use cannabis if I am pregnant or if I am breastfeeding.

Contemporaneous Use of Cannabis with Alcohol. I understand that using cannabis while under the influence of alcohol is not recommended, and is further discouraged by Greenhouse Integrative Medicine, LLC. Additional side effects may become present when using both cannabis and alcohol.

Minors. I acknowledge and understand that if I am under eighteen (18) years of age, I must have a primary care giver to obtain medical cannabis. My primary caregiver must be my parent or legal guardian, an individual designated by my parent or legal guardian, or an appropriate individual approved by the Department of Health of the Commonwealth upon a sufficient showing that no parent or legal guardian is appropriate or available.

FDA; Federal Law and Regulations. The Food and Drug Administration of the United States (the "FDA") has not approved or otherwise acknowledged cannabis as a safe and effective food, plant, or drug for any use or indication. Therefore, cannabis may contain unknown quantities of active ingredients, impurities, and/or contaminants. I am aware that a Notice of Compliance has not been issued under the current FDA Regulations concerning the safety and effectiveness of cannabis. I am further aware that medical cannabis has not been approved under current federal regulations and I understand that medical cannabis has not been deemed legal under federal law. I acknowledge and understand the forgoing.

Daycare; Schools. I acknowledge and understand that I am not permitted to smoke within one thousand (1,000) feet of any daycare, school, or within any school zone. If I reside near such institutions, I must use my medical cannabis within the privacy of my own home.

Change In Medical Conditions and/or Records. I agree to follow up and communicate with Greenhouse Integrative Medicine, LLC if any of my medical conditions or medical records change. I acknowledge and understand that it is my sole responsibility to update my medical conditions and records as they persist and/or change.

Pennsylvania Residency Required. I understand that I must be a resident of the **Commonwealth of Pennsylvania** to obtain a recommendation and prescription from a licensed physician for the obtainment and use of medical cannabis. I certify and attest that I am a Pennsylvania resident.

Quality of Life. I affirm that I have a serious medical condition that negatively affects my overall quality of life. I have found that, or I am interested in discovering if, medical cannabis provides substantial relief, improvement to my condition, and/or improves my overall quality of life.

Acknowledgement and Certification

I understand that Greenhouse Integrative Medicine, LLC does not provide, dispense, sell, or encourage the use of medical cannabis. I also acknowledge and understand that Greenhouse Integrative Medicine, LLC will NOT be providing or discussing information regarding the services of a dispensary, co-op, delivery service, or any other method to obtain medical cannabis.

I certify that I have read the forgoing document and declare, under penalty of perjury, that the information contained herein is true, accurate, correct, and complete to the best of my knowledge. I acknowledge and understand that any manipulation, alteration, or falsification of this form shall result in the immediate termination of any legal right pertaining to my use of medical cannabis. Furthermore, if I manipulate, alter, or falsify anything in this form, such activities will be reported to the appropriate local and state authorities, for which I may be subject to potential legal penalties, including, without limitation, fines or imprisonment.

Greenhouse Integrative Medicine, LLC, its physicians, and staff are in no way establishing themselves as my primary care physician or primary health provider. Furthermore, I, my heirs, assigns, or any other authorized representative acting on my behalf, hold Greenhouse Integrative Medicine, LLC, its principals, agents, and employees, harmless and free from any responsibility, legal or otherwise, for any harm to me and/or any other third party as a result of my medical cannabis use.

In requesting an approval or recommendation for the use of medical cannabis, I assume full responsibility for any and all risks associated therewith. I also assume full responsibility for any and all risks associated with any cannabis treatment or use.

Patient Name: _____ **Date of Birth:** _____

Signature of Patient: _____ **Date:** _____

Signature of Parent/Legal Guardian: _____

Pennsylvania's Medical Marijuana Act, Senate Bill 3, approved April 12, 2016

Pennsylvania's Medical Marijuana Act provides for the possession and use of medical cannabis for patients suffering from serious medical conditions upon approval or recommendation from a licensed physician.

I, the undersigned, hereby request a consultation by Greenhouse Integrative Medicine, LLC for the purposes of determining the appropriateness of medicinal cannabis 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 of Greenhouse Integrative Medicine, LLC are addressing specific aspects of my medical care, and unless otherwise stated, are in no way establishing themselves as my primary care physician or provider. Should an approval be made for my use of medical cannabis, I understand that there is a renewal date specified by the physician depending on my medical condition(s). I understand that it is my responsibility to schedule an appointment with Greenhouse Integrative Medicine, LLC to assess the potential continuance of cannabis use beyond the initial term of approval.

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

Patient Name: _____ **Date of Birth:** _____

Signature of Patient: _____ **Date:** _____

Signature of Parent/Legal Guardian: _____

Medical Cannabis Patient Declaration

I hereby certify and declare that I have completely, truthfully, and accurately disclosed all pertinent information regarding my medical condition, and I attest that I do not intend to use my medical cannabis recommendation for the purpose of illegally obtaining, growing, distributing, or selling medical cannabis to any third party.

I certify and attest that I am not a member, employee, or agent of any media or law enforcement agency. I acknowledge and understand that it is illegal to film or record with a video camera, cell phone, or any other recording devise, be it a still image, video, or audio, in this office without the prior written consent and authorization of Greenhouse Integrative Medicine, LLC. Such recordings are a direct violation of HIPAA regulations and patient/doctor confidentiality.

I acknowledge and understand that my recommendation for medical cannabis use can be revoked at any time and for any reason. I further acknowledge and understand that legal actions will be taken by Greenhouse Integrative Medicine, LLC and/or any authorized governmental agency if I have perjured, misrepresented my condition, my intentions, or myself, or falsified any medical records to Greenhouse Integrative Medicine, LLC, its physicians, its staff, or any of its authorized representatives or agents. I also hereby authorize Greenhouse Integrative Medicine, LLC to discuss my medical condition with third parties for verification purposes only.

Patient Name: _____ **Date of Birth:** _____

Signature of Patient: _____ **Date:** _____

Signature of Parent/Legal Guardian: _____

Home Street Address: _____

City, State, Zip Code: _____

Home Phone Number: _____ **Cell Phone Number:** _____