



Medical Cannabis New Patient Intake Form & Consent Form

ALL ABOUT MEDICINE

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IMPORTANT: All pages must be completed and returned to our office prior to your scheduled appointment. If you have any questions regarding these forms, please contact us prior to your appointment so we may assist you. Incomplete forms may delay medical cannabis treatments.



ALL ABOUT MEDICINE

This is the Medical Cannabis Physicians patient intake questionnaire. To be considered for medical Marijuana, all information must be provided:

Name_____ Date_____DOB_____

Address_____

County_____

FL Driver's License #_____

Height_____Weight_____

SSN _____Phone #_____

Email address_____

Primary Care Physician and phone number_____

Reason for cannabis treatment (circle one or more)

Muscle Spasms • Seizures • Cancer • Glaucoma • Crohn's Disease • HIV/AIDS • PTSD • ALS
• Parkinson's Disease • Multiple Sclerosis • Terminal illness • Severe Nausea • Paraplegia
• Quadriplegia • Chronic Pain • Other debilitating illness (explain)_____

Please list symptoms you experience, frequency, severity and duration

Symptom	Frequency	Severity	Duration
1. _____			
2. _____			
3. _____			
4. _____			
5. _____			
6. _____			
7. _____			
8. _____			
9. _____			
10. _____			

Please list all treatments you've tried, how long was each treatment attempted, and outcomes of each treatment

Treatment	Duration	Outcome
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		
6. _____		
7. _____		
8. _____		
9. _____		
10. _____		

Do you smoke cigarettes? y/n how much _____ how many years _____

Do you drink alcohol? y/n how much _____ how often _____

Do you use illegal drugs? y/n type _____ How often _____

Please list all your medical illnesses:

1. _____	5. _____	9. _____
2. _____	6. _____	10. _____
3. _____	7. _____	11. _____
4. _____	8. _____	12. _____

Please list all current medications dosage and how many times a day

Name of Medication	Dose.	Frequency
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		
6. _____		
7. _____		
8. _____		
9. _____		
10. _____		

Please list any allergies: _____

Consent Form

A qualified physician may not delegate the responsibility of obtaining written informed consent to another person. The qualified patient or the patient's parent or legal guardian (if the patient is a minor) must initial each section of this consent form to indicate that the physician explained the information and, along with the qualified physician, must sign and date the informed consent form.

I, _____ (Print Patient Name), understand that Medical Cannabis is offered as treatment for specific medical conditions and/or symptoms as designated by the Florida Department of Health, Office of Compassionate Use.

PLEASE INITIAL EACH SECTION

___ I understand that Dr. Amir Etemadnia is a qualified physician who is registered with the Office of Compassionate Use and may order medical cannabis for my medical use if he feels I qualify as a patient who could benefit from this medical decision.

___ I understand that Dr. Amir Etemadnia is not implying or suggesting that medical cannabis should be a substitute for any other treatment prescribed by another physician.

___ I understand that I may not seek medical cannabis from any other physician while being a registered patient with Dr. Amir Etemadnia.

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

___ I am aware that a notice of compliance has not been issued under the Food and Drug Administration's 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 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 agree that if I am a female patient that I will contact my attending physician if I become or think 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 should not drive a vehicle while using medical marijuana and that I can get a DUI for driving under the influence.

___ I understand that Dr. Amir Etemadnia will register my case with the Florida Department of Health, Compassionate Use Registry and he will submit the treatment plan quarterly to the institution as designated by the legislature for the State of Florida for research purposes on the efficacy of medical cannabis to help treat patients.

___ I understand that I may fill the order placed by Dr. Amir Etemadnia at any qualified dispensing organization. The dispensary will verify identity of the patient as well as the existence of an order in the Registry of Compassionate Use, a maximum of seventy (70) day supply is allowed.

___ I understand that when treatment is discontinued, Dr. Amir Etemadnia will deactivate my registration with the Compassionate Use Registry.

The Federal Government's classification of marijuana as a Schedule I controlled substance.

___ The federal government has classified marijuana as a Schedule I controlled substance. Schedule I substances are defined, in part, as having (1) a high potential for abuse; (2) no currently accepted medical use in treatment in the United States; and (3) a lack of accepted safety for use under medical supervision. Federal law prohibits the manufacture, distribution and possession of marijuana.

___ When in the possession or under the influence of medical marijuana, the patient or the patient's caregiver must have his or her medical marijuana use registry identification card in his or her possession at all times.

The approval and oversight status of marijuana by the Food and Drug Administration.

___ Marijuana has not been approved by the Food and Drug Administration for marketing as a drug. Therefore, the “manufacture” of marijuana for medical use is not subject to any federal standards, quality control, or other oversight. Marijuana may contain unknown quantities of active ingredients, which may vary in potency, impurities, contaminants, and substances in addition to THC, which is the primary psychoactive chemical component of marijuana.

The potential for addiction.

___ Some studies suggest that the use of marijuana by individuals may lead to a tolerance to, dependence on, or addiction to marijuana. I understand that if I require increasingly higher doses to achieve the same benefit or if I think that I may be developing a dependency on marijuana, I should contact Dr. Amir Etemadnia.

The potential effect that marijuana may have on a patient’s coordination, motor skills, and cognition, including a warning against operating heavy machinery, operating a motor vehicle, or engaging in activities that require a person to be alert or respond quickly.

___ The use of marijuana can affect coordination, motor skills and cognition, i.e., the ability to think, judge and reason. Driving under the influence of cannabis can double the risk of crashing, which escalates if alcohol is also influencing the driver. While using medical marijuana, I should not drive, operate heavy machinery or engage in any activities that require me to be alert and/or respond quickly and I should not participate in activities that may be dangerous to myself or others. I understand that if I drive while under the influence of marijuana, I can be arrested for “driving under the influence.”

The potential side effects of medical marijuana use.

___ 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, may affect the production of sex hormones that lead to adverse effects, inability to concentrate, impaired motor skills, paranoia, psychotic symptoms, general apathy, depression and/or restlessness. Marijuana may exacerbate schizophrenia in persons predisposed to that disorder. In addition, the use of medical marijuana may cause me to talk or eat in excess, alter my perception of time and space and impair my judgment. Many medical authorities claim that use of medical marijuana, especially by persons younger than

25, can result in long-term problems with attention, memory, learning, drug abuse, and schizophrenia.

___ I understand that using marijuana while consuming alcohol is not recommended. Additional side effects may become present when using both alcohol and marijuana.

___ I agree to contact Dr. Amir Etemadnia if I experience any of the side effects listed above, or if I become depressed or psychotic, have suicidal thoughts, or experience crying spells. I will also call 911 if I experience respiratory problems, changes in my normal sleeping patterns, extreme fatigue, increased irritability, or begin to withdraw from my family and/or friends.

The risks, benefits, and drug interactions of marijuana.

___ Signs of withdrawal can include: feelings of depression, sadness, irritability, insomnia, restlessness, agitation, loss of appetite, trouble concentrating, sleep disturbances and unusual tiredness.

___ Symptoms of marijuana overdose include, but are not limited to, nausea, vomiting, hacking cough, disturbances in heart rhythms, numbness in the hands, feet, arms or legs, anxiety attacks and incapacitation. If I experience these symptoms, I agree to contact Dr. Amir Etemadnia immediately or go to the nearest emergency room.

___ Numerous drugs are known to interact with marijuana and not all drug interactions are known. Some mixtures of medications can lead to serious and even fatal consequences. I agree to follow the directions of Dr. Amir Etemadnia regarding the use of prescription and non-prescription medication. I will advise any other of my treating physician(s) of my use of medical marijuana.

___ Marijuana may increase the risk of bleeding, low blood pressure, elevated blood sugar, liver enzymes, and other bodily systems when taken with herbs and supplements. I agree to contact Dr. Amir Etemadnia immediately or go to the nearest emergency room if these symptoms occur.

___ I understand that medical marijuana may have serious risks and may cause low birthweight or other abnormalities in babies. I will advise Dr. Amir Etemadnia if I become pregnant, try to get pregnant, or will be breastfeeding.

The current state of research on the efficacy of marijuana to treat the qualifying conditions set forth in this section.

___Cancer:

- There is insufficient evidence to support or refute the conclusion that cannabinoids are an effective treatment for cancers, including glioma.

There is evidence to suggest that cannabinoids (and the endocannabinoid system more generally) may play a role in the cancer regulation processes. Due to a lack of recent, high-quality reviews, a research gap exists concerning the effectiveness of cannabis or cannabinoids in treating cancer in general.

- There is conclusive evidence that oral cannabinoids are effective antiemetics in the treatment of chemotherapy-induced nausea and vomiting.

There is insufficient evidence to support or refute the conclusion that cannabinoids are an effective treatment for cancer-associated anorexia-cachexia syndrome and anorexia nervosa.

___Epilepsy:

- There is insufficient evidence to support or refute the conclusion that cannabinoids are an effective treatment for epilepsy.

Recent systematic reviews were unable to identify any randomized controlled trials evaluating the efficacy of cannabinoids for the treatment of epilepsy.

Currently available clinical data therefore consist solely of uncontrolled case series, which do not provide high-quality evidence of efficacy. Randomized trials of the efficacy of cannabidiol for different forms of epilepsy have been completed and await publication.

___Glaucoma:

- There is limited evidence that cannabinoids are an ineffective treatment for improving intraocular pressure associated with glaucoma.

Lower intraocular pressure is a key target for glaucoma treatments. Non- randomized studies in healthy volunteers and glaucoma patients have shown short-term reductions in intraocular pressure with oral, topical eye drops, and intravenous cannabinoids, suggesting the potential for therapeutic benefit. A good-quality systemic review identified a single small trial that found no effect of two cannabinoids, given as an oromucosal spray, on intraocular pressure. The quality of evidence for the finding of no effect is limited. However, to be effective, treatments targeting lower intraocular pressure must provide continual rather than transient reductions in intraocular pressure. To date, those studies showing positive effects have shown only short-term benefit on intraocular pressure (hours), suggesting a limited potential for cannabinoids in the treatment of glaucoma.

___Positive status for human immunodeficiency virus AND acquired immune deficiency syndrome:

- There is limited evidence that cannabis and oral cannabinoids are effective in increasing appetite and decreasing weight loss associated with HIV/AIDS.

There does not appear to be good-quality primary literature that reported on cannabis or cannabinoids as effective treatments for AIDS wasting syndrome.

___Post-traumatic stress disorder:

- There is limited evidence (a single, small fair-quality trial) that nabilone is effective for improving symptoms of posttraumatic stress disorder.

A single, small crossover trial suggests potential benefit from the pharmaceutical cannabinoid nabilone. This limited evidence is most applicable to male veterans and contrasts with non-randomized studies showing limited evidence of a statistical association between cannabis use (plant derived forms) and increased severity of posttraumatic stress disorder symptoms among individuals with posttraumatic stress disorder. There are other trials that are in the process of being conducted and if successfully completed, they will add substantially to the knowledge base.

___Amyotrophic lateral sclerosis:

- There is insufficient evidence that cannabinoids are an effective treatment for symptoms associated with amyotrophic lateral sclerosis.

Two small studies investigated the effect of dronabinol on symptoms associated with ALS. Although there were no differences from placebo in either trial, the sample sizes were small, the duration of the studies was short, and the dose of dronabinol may have been too small to ascertain any activity. The effect of cannabis was not investigated.

___ **Crohn's disease:**

- There is insufficient evidence to support or refute the conclusion that dronabinol is an effective treatment for the symptoms of irritable bowel syndrome.

Some studies suggest that marijuana in the form of cannabidiol may be beneficial in the treatment of inflammatory bowel diseases, including Crohn's disease.

___ **Parkinson's disease:**

- There is insufficient evidence that cannabinoids are an effective treatment for the motor system symptoms associated with Parkinson's disease or the levodopa- induced dyskinesia.

Evidence suggests that the endocannabinoid system plays a meaningful role in certain neurodegenerative processes; thus, it may be useful to determine the efficacy of cannabinoids in treating the symptoms of neurodegenerative diseases. Small trials of oral cannabinoid preparations have demonstrated no benefit compared to a placebo in ameliorating the side effects of Parkinson's disease. A seven-patient trial of nabilone suggested that it improved the dyskinesia associated with levodopa therapy, but the sample size limits the interpretation of the data. An observational study demonstrated improved outcomes, but the lack of a control group and the small sample size are limitations.

___ **Multiple sclerosis:**

- There is substantial evidence that oral cannabinoids are an effective treatment for improving patient-reported multiple sclerosis spasticity symptoms, but limited evidence for an effect on clinician-measured spasticity.

Based on evidence from randomized controlled trials included in systematic reviews, an oral cannabis extract, nabiximols, and orally administered THC are probably effective for reducing patient-reported spasticity scores in patients with MS. The effect

appears to be modest. These agents have not consistently demonstrated a benefit on clinician-measured spasticity indices.

___ Medical conditions of same kind or class as or comparable to the above qualifying medical conditions:

- The qualifying physician has provided the patient or the patient's caregiver a summary of the current research on the efficacy of marijuana to treat the patient's medical condition.
- Terminal conditions diagnosed by a physician other than the qualified physician issuing the physician certification
- The qualifying physician has provided the patient or the patient's caregiver a summary of the current research on the efficacy of marijuana to treat the patient's terminal condition.

___ Chronic nonmalignant pain:

- There is substantial evidence that cannabis is an effective treatment for chronic pain in adults.

The majority of studies on pain evaluated nabiximols outside the United States. Only a handful of studies have evaluated the use of cannabis in the United States, and all of them evaluated cannabis in flower form provided by the National Institute on Drug Abuse. In contrast, many of the cannabis products that are sold in state-regulated markets bear little resemblance to the products that are available for research at the federal level in the United States. Pain patients also use topical forms.

While the use of cannabis for the treatment of pain is supported by well- controlled clinical trials, very little is known about the efficacy, dose, routes of administration, or side effects of commonly used and commercially available cannabis products in the United States.

That the patient's de-identified health information contained in the physician certification and medical marijuana use registry may be used for research purposes

___The Department of Health submits a data set to The Medical Marijuana Research and Education Coalition for each patient registered in the medical marijuana use registry that includes the patient's qualifying medical condition and the daily dose amount and forms of marijuana certified for the patient

___I have had the opportunity to discuss these matters with the physician and to ask questions regarding anything I may not understand or that I believe needed to be clarified. I acknowledge that Dr. Amir Etemadnia has informed me of the nature of a recommended treatment, including but not limited to, any recommendation regarding medical marijuana.

By signing this document, I voluntarily agree that all my questions have been addressed; benefits and risks have been discussed. I understand no fees associated with care or obtaining medical cannabis can be applied to any insurance plan, according to Florida State Law. Myself or my legal representative prior to evaluation of treatment will pay all fees.

Print name: _____

Or legal representative: _____

Signature: _____

Date: _____

Witness: _____

Print name: _____ Date: _____



Cancellation Policy

We at ALL ABOUT MEDICINE value your business and care greatly about your health. One of our primary concerns is maintaining our appointment schedule so that we may be available to our patients. In order for us to do so, it is crucial that once scheduled, you promptly notify our office of any change in your appointment needs.

For these reasons, we have established a policy to assess a \$75.00 fee to reserve your Cannabis appointment which will be applied to your first visit. However, if you miss your appointment this fee is non-refundable.

We appreciate your cooperation in this matter so that we may provide you with the best possible care.

I understand the above fee for the Cannabis appointment and that it is non-refundable if I should miss my appointment.

Signed _____ Date: _____

Signature of Witness _____



Disclosure Form

I hereby authorize the disclosure of my personal and complete health information from my health records such as my name, Date of Birth, SSN, Address and Contact information to be used

by my Medical Cannabis Physician for the purpose of treatment, payment, and/or healthcare operations unless otherwise specified

Information to be disclosed:

Complete health records

Records from previous physicians

Billing information

Progress notes

Operative reports

Consultation reports

Radiology reports

Personal contact information

Pathology reports

Laboratory tests

Other (please specify)

I understand that by signing this form, I give special authorization allowing the release of any information from my health record regarding acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) infection, behavioral health service/psychiatric care, or treatment for alcohol and/or drug abuse unless otherwise specified as follows:

The practice *will not* receive payment or other remuneration from a third party in exchange for using or disclosing PHI.

I understand that HIPPA regulations and Florida law require that information contained in my medical records be held in strict confidence and not be released without my written authorization. The authorizations I sign on this page will remain in effect until I request in writing that my authorizations be revoked, which I may do at any time. I understand that a revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I also have the right to receive a copy of this authorization upon my request.

The practice/facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information authorized herein. I understand that authorizing the release of this health information is voluntary, and that I may refuse to sign this authorization. I am not required to sign this form to assure treatment. I understand I may inspect or copy the information to be used or released. I understand any release of information carries with it the potential for an unauthorized re-release and the information may not be protected by federal confidentiality rules.

Signed _____ Patient/Guardian Date: _____

Signature of Witness _____

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PATIENT INFORMATION SHEET

NAME: _____ GENDER: _____ DOB: _____ DATE: _____
ALLERGIES: _____

List ALL MEDICATIONS you take, including over-the-counter (OTC) medications and vitamins

_____	_____	_____
_____	_____	_____
_____	_____	_____

PERSONAL MEDICAL HISTORY: (Please circle all that apply)

ADHD	COPD/ Emphysema	High Cholesterol	Rheumatoid Arthritis
Alcoholism	Dementia	HIV	Seizure Disorder
Allergies, Seasonal	Depression	Hepatitis	Sleep Apnea
Anemia	Diabetes: 1 or 2	Irritable Bowel Syndrome	Stroke
Anxiety	Diverticulitis	Lupus	Thyroid Disorder
Arrhythmia (irregular heart beat)	DVT (Blood Clot)	Liver Disease	Ulcerative Colitis
Arthritis	GERD (Acid Reflux)	Macular Degeneration	
Asthma	Glaucoma	Neuropathy	
Bipolar	Heart Disease	Osteopenia/Osteoporosis	
Bladder Problems / Incontinence	Heart Attack (MI)	Parkinson's Disease	
Bleeding Problems	Hiatal Hernia	Peripheral Vascular Disease	
Cancer: _____	High Blood Pressure	Peptic Ulcer	
Headaches	Kidney Stones	Psoriasis	
Crohn's Disease	Kidney Disease	Pulmonary Embolism (PE)	

Last Menstrual Period	Date: _____	Normal Abnormal
Colonoscopy		Normal Abnormal
Mammogram		Normal Abnormal
Dexa (Bone Density)		Normal Abnormal
Pap		Normal Abnormal

Other medical problems not listed above:

Surgical History: Please list all prior surgeries and approximate dates performed.

_____	_____
_____	_____

SOCIAL / CULTURAL HISTORY:

Education Level: ☐ Elementary ☐ High School ☐ Vocational ☐ College ☐ Graduate / Professional

Are there any vision problems that affect your communication? ☐ Yes ☐ No

Are there any hearing problems that affect your communication? ☐ Yes ☐ No

Are there any limitations to understanding or following instructions (either written or verbal)? ☐ Yes ☐ No

Current Living Situation (Check all that apply):

Smoking/ Tobacco Use: ☐ Current ☐ Past ☐ Never Type: _____ Amount/day: _____ Number of Years: _____

Alcohol: ☐ Current ☐ Past ☐ Never Drinks/week: _____

Recreational Drug Use: ☐ Current ☐ Past ☐ Never Type: _____

Are you sexually active? ☐ Yes ☐ No

Are there any personal problems or concerns at home, work, or school you would like to discuss? ☐ Yes ☐ No

Are there any cultural or religious concerns you have related to our delivery of care? ☐ Yes ☐ No

Are there any financial issues that directly impact your ability to manage your health? ☐ Yes ☐ No

How often do you get the social and emotional support you need?

☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never

Comments (Please feel free to comment on any answers marked “yes” above):

FAMILY HISTORY:

FATHER: Living: Age _____ Deceased: Age _____

Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer: _____	Diabetes 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/Emphysema	DVT (Blood Clot)	Kidney Disease	Thyroid Disorder
Arthritis	Dementia	Heart Disease	Migraines	

Other: _____

MOTHER: Living: Age _____ Deceased: Age _____

Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer: _____	Diabetes 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/Emphysema	DVT (Blood Clot)	Kidney Disease	Thyroid Disorder
Arthritis	Dementia	Heart Disease	Migraines	

Other: _____

SIBLINGS:

List other medical providers you see on a regular basis (i.e. Cardiologist, Mental Health Provider, Kidney Doctor, Dentist, etc.)

Patient Signature: _____ Date: _____



AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Patient Name _____ Date of Birth _____

Authorization for Use/Disclosure of Information: I voluntarily consent to an authorize my health care provider _____ (insert name) to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below.

Recipient: I authorize my health care information to be released to the following recipient(s):

Name: _____

Address: _____

Purpose: I authorize the release of my health information for the following specific purpose:

_____.
(Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization)

Information to be disclosed: I authorize the release of the following health information:
(check the applicable box below)

- ☐ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.¹
- ☐ Only the following records or types of health information:

_____.

Term: I understand that this Authorization will remain in effect:

¹ NOTE: This Authorization does not extend to HIV test results, outpatient psychotherapy notes, drug or alcohol treatment records that are protected by federal law, or mental health records that are protected by the Lanterman-Petris-Short Act.

- ☐ From the date of this Authorization
- ☐ Until the Provider fulfills this request.
- ☐ Until 2 years after patient is deceased

Redisclosure: I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation or quality of my treatment at Medical Cannabis Physicians of Florida. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to Medical Cannabis Physicians of Florida at the address listed below. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

Questions: I may contact the office for answers to my questions about the privacy of my health information at 10125 W Colonial Drive Suite 101 Ocoee FL 34761 or by telephone at 407-777-2503

Print Name _____

Signature _____ Date _____

Signature of Witness If Individual is unable to sign this Authorization, please complete the information below:

Name of Guardian/
Representative

Legal Relationship

Date

Witness

