Green Valley Wellness – Our Process

Thank you for considering Green Valley Wellness. We're dedicated to assisting you with obtaining your legal authorization through the Access to Cannabis for Medical Purposes Regulations (ACMPR).

As medical cannabis patients ourselves, we are aware of the difficulties that patients face when talking to their Physicians about medical cannabis. This is why we are here to help!

We try to keep the process simple for every patient across Canada.

Our initial consultation, where we assess and determine your potential eligibility, is always free. The initial consultation can happen in our office, on Skype or over the phone.

During the consultation, our Patient Educators will do the following:

- Determine if you may be eligible for medicinal cannabis through the ACMPR
- Discuss the difference between THC/CBD and Sativa/Indica strains
- Discuss dosage, titration and treatment plans for each patient
- Talk about the legally authorized Licensed Producers within the ACMPR
- Discuss how you can produce your own cannabis through the ACMPR
- Discuss if you could benefit from any other Wellness Services offered at our location

In order for you to qualify, you will need to include "supporting documents" that outline proof of your medical diagnosis. Examples of documents that can be accepted include:

- A written letter of diagnosis from a health care practitioner
  (Physician, Physician Specialist, Nurse Practitioner, Naturopath, Chiropractor, Physiotherapist etc.)

If you do not have access to your medical records or do not take pharmaceuticals, we can assist you with arranging an assessment with a qualified individual to obtain an official diagnosis of your medical condition(s).

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Once you have completed the application package, you may drop it off in person or scan the competed application package and email it back to info@gvwellness.ca with the "supporting document" as well as a copy of Valid picture ID. (Drivers License, Passport or Age of Majority Card is accepted. Health Cards are not.)

During this time, we will discuss which Licensed Producer that you would like to purchase your medical cannabis from. We will also assist with registration for the Licensed Producer.

We will require 50% of the consulting package fee, previous to arranging the consultation with the Physician Specialist/Physician/Nurse Practitioner. The remaining balance will be due after your consultation with the Physician Specialist/Physician/Nurse Practitioner.
***(Fees do not apply to small consulting packages for patients with Cancer, CRPS, MS or for Veterans, Seniors and First Responders.)**

Once all documents are forwarded to the Physician Specialist/Physician/Nurse Practitioner, they will review the information to see if you qualify. Once approved, the date and time of the consultation will be set and communicated to you.

After the consultation with the Physician Specialist/Physician/Nurse Practitioner, they will sign the required medical document and send it to the Licensed Producer that you picked. You will then officially become a legally authorized medical cannabis patient in Canada!

If you are a patient who will be producing your own medical cannabis, we will arrange for you to receive the additional medical document and assist you with the paperwork required by Health Canada. Health Canada's process will take several months for you to be approved to legally produce your medicine. Green Valley Wellness advises not to begin producing medical cannabis until after Health Canada has approved your application for production.

If you have any questions or concerns, you may contact us at anytime. Thank you once again for choosing Green Valley Wellness and we look forward to assisting you!

PATIENT INFORMATION

Patient's Name: _____ Date of Birth: _____

Address: _____ Postal Code: _____ City/Prov.: _____

Phone #: _____ E-Mail: _____

Skype Username: _____ Referred By: _____

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

Designated Grower? Yes ☐

PATIENT MEDICAL INFORMATION

*** Please attach any medical documents or other supporting documents with your medical diagnosis**

Medical Diagnosis: _____

Requested Grams Per Day: _____

Preferred Licensed Producer: _____

PATIENT ASSESSMENT

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	☐	Difficulty Sleeping	☐	Muscle Spasms
☐	Anxiety	☐	Fatigue	☐	Nausea
☐	Back Pain	☐	Foot Pain	☐	Neck Pain
☐	Chronic Pain	☐	Headaches	☐	Seizures
☐	Constipation	☐	Hip Pain	☐	Shaking
☐	Depression	☐	Low Energy	☐	Vision Issues
☐	Diarrhea	☐	Menstrual Pains	☐	Weakness
☐	Difficulty Eating	☐	Mobility Issues	☐	Weight Loss

_____ _____

PATIENT SIGNATURE DATE

Patient Consent to Disclose Personal Health Information (PHI) Form

Patient's Name: _____ Date of Birth: _____

Address: _____ Postal Code: _____ City: _____ Prov.: _____

Phone #: _____ E-Mail: _____

I, _____, consent to the release of personal health information (PHI) to Green Valley Wellness by way of unsecured email/Skype. I also recognize that other options have been made available to me by way of faxing my personal health information directly to the office of the Physician Specialist/Physician/Nurse Practitioner, to which I am having my medical assessment.

I understand that sending personal health information through unsecure email is not necessarily at a high risk of diversion, but this risk is substantially lowered when sending personal health information by way of fax.

I authorize Green Valley Wellness to share my personal health information with the Physician Specialists/Physicians/Nurse Practitioners clinic to which I wish to have an assessment and any other parties involved with the process of obtaining my Medical Document.

I understand the purpose for disclosing this personal health information to Green Valley Wellness and I understand that I can refuse to sign this form.

I hereby release Green Valley Wellness, the assessing Physician Specialist/Physician/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.

SIGNATURE: _____ DATE SIGNED: _____

Release, Acknowledgement & 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 Specialist/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 Specialist/Physician/Nurse Practitioner will not necessarily be assuming primary care for me, but 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.

The Physician Specialist/Physician/Nurse Practitioner will weigh the risks versus the rewards in treating my medical condition(s) and any associated symptoms, with medical cannabis. I confirm that the assessing Physician Specialist/Physician/Nurse Practitioner will be the only practitioner providing a medical document under the ACMPR for the purpose of possessing/cultivating and consuming medical cannabis.

I agree to make no claims or commence any legal action against Green Valley Wellness, the assessing Physician Specialist/Physician/Nurse Practitioner, my family Physician or any other involved Physicians/parties in regards to:

a) My consumption of medical cannabis from the Licensed Producers or cultivated by myself
b) My Application or medical document(s) for possessing, obtaining, cultivating and consuming medical cannabis

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

-May effect sight, sounds and touch
-May impair thinking, problem-solving, coordination, memory and learning
-May increase heart rate and reduce blood pressure
-May induce anxiety, fear, distrust, or panic

I am aware that medical conditions such as schizophrenia, atrial fibrillation, Heart attack/stroke or 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.

I am aware that while purchasing my medical cannabis from a Licensed Producer or producing my own medical cannabis is legal, I agree that I will not resell my medical cannabis.

FOR PATIENTS Pursuing an ACMPR Medical Document

I am aware of the considerable debate and a lack of consensus among Physician Specialists/Physicians/Nurse Practitioners about;

-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 long term psychological and health risks associated with medical cannabis

-The risk of pulmonary infections and respiratory cancer

-The risk of triggering mental illness, such as bipolar disorder and schizophrenia

-The risk of nausea and disorientation

I consent to the disclosure and sharing and use of my personal information and personal health information by way of unsecured Email/Skype, by the assessing Physician Specialist/Physician/Nurse Practitioner, Green Valley Wellness, my Licensed Producer or any parties involved with the process of obtaining my Medical Document. The information may be used to contact and register the patient. The information may also be used for analytical and research purposes.

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.

This is my personal decision to possess and consume medical cannabis and I do not support any claims made by family, friends or other individuals against Green Valley Wellness, the prescribing Physician Specialist/Physician/Nurse Practitioner and any other parties involved with the process of obtaining my Medical Document.

I hereby release Green Valley Wellness, the assessing Physician Specialist/Physician/Nurse Practitioner and any other parties involved with the process of obtaining my Medical Document, from any and all claims, actions, causes of actions, complaints (including friends and family) and demands for damages, loss, or injury arising directly or indirectly to my use of medical cannabis and my application to possess, cultivate or consume medical cannabis.

This release from liability is to be binding on heirs, executors and signs and I acknowledge that I have the right to refuse to sign this form.

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

1. Within 4 (FOUR) hours of inhaling cannabis vapour 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" Remember to keep all cannabis products, and medicines, in a Locked Box.

PRINT NAME: _____ WITNESS PRINT NAME: _____

SIGNATURE: _____ SIGNATURE: _____

DATE SIGNED: _____ DATE SIGNED: _____

Brief Pain Inventory

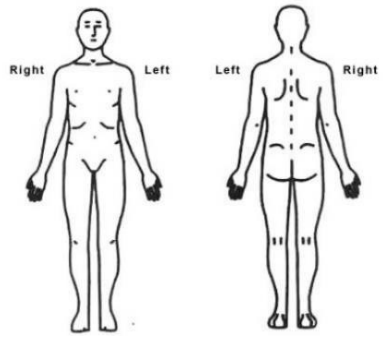
Name: _____ **Date:**

Time: _____

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?

Yes No

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



3. Please rate your pain by circling the one number that best describes your pain at its **worst** in the past 24 hours.

0 1 2 3 4 5 6 7 8 9 10

No Pain *Pain as bad as you can imagine*

4. Please rate your pain by circling the one 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

No Pain *Pain as bad as you can imagine*

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

0 1 2 3 4 5 6 7 8 9 10

No Pain *Pain as bad as you can imagine*

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

0 1 2 3 4 5 6 7 8 9 10

No Pain *Pain as bad as you can imagine*

8. In the past 24 hours, how much relief have pain treatments or medications provided? Please circle the one percentage that most shows how much relief you have received.

0% 10 20 30 40 50 60 70 80 90 100%

No Relief *Complete Relief*

9. Circle the one number that describes how, during the past 24 hours, pain has interfered with your: a) General Activity

0 1 2 3 4 5 6 7 8 9 10

Not at all *Greatly Interferes*

b) Mood

0 1 2 3 4 5 6 7 8 9 10

Not at all *Greatly Interferes*

c) Walking ability

0 1 2 3 4 5 6 7 8 9 10

Not at all *Greatly Interferes*

d) Normal Work (includes both work outside/home/housework)

0 1 2 3 4 5 6 7 8 9 10

Not at all *Greatly Interferes*

e) Relations with other people

0 1 2 3 4 5 6 7 8 9 10

Not at all *Greatly Interferes*

f) Sleep

0 1 2 3 4 5 6 7 8 9 10

Not at all *Greatly Interferes*

g) Enjoyment of life

0 1 2 3 4 5 6 7 8 9 10

Not at all *Greatly Interferes*

h) Ability to concentrate

0 1 2 3 4 5 6 7 8 9 10

Not at all *Greatly Interferes*

i) Appetite

0 1 2 3 4 5 6 7 8 9 10

Not at all *Greatly Interferes*

10. In the area where you have pain, do you have "pins and needles", tingling or prickling sensations?

Yes *No*

11. Does the painful area change colour (perhaps mottled or red) when the pain is particularly bad?

Yes *No*

12. Does your pain make the affected skin abnormally sensitive to the touch?

Yes *No*

13. Does your pain come on suddenly and in bursts for no apparent reason when you are completely still?

Yes *No*

14. In the area where you have pain, does your skin feel unusually hot like burning pain?

Yes *No*

15. Gently ***rub*** the painful area with your index finger and then rub a non-painful area. How does the rubbing feel in the painful area?

☐ No difference

☐ Discomfort – pins and needles, tingling or burning in the painful area

16. Gently ***press*** on the painful area with your fingertip then gently press in the same way to a non painful area. How does this feel in the painful area?

☐ No difference

☐ Discomfort – pins and needles, tingling or burning in the painful area

Modified from McCaffery M, Pasero C: Pain: Clinical manual, p 61, 1999, Mosby, Inc. From Pain Research Group, Department of Neurology, University of Wisconsin-Madison. Bennett MI 2001 PAIN 92:147-157

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

Patient Health Questionnaire (PHQ-9)

Name: _____ Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

For office coding: Total Score _____ = _____ + _____ + _____

Total Score _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Name: _____ Date: _____

Birth Date: _____ Height: _____ Weight: _____

Medical Cannabis Assessment

Do you currently use marijuana for relief? No Yes
If YES above, how many times a day do you use it? _____
How long have you used it medically? _____
When did you last use it? _____ If you do not obtain a prescription for marijuana, will you continue to use it? No Yes

Do you smoke tobacco? No Yes - cigarettes, cigars, pipe- number per day. _____

Do you use medicines containing opiates? (Codeine, morphine, other) No Yes
If Yes, which ones do you use, how often and what dosage? _____

Do you use cocaine or other "street" drugs? No Yes
If Yes, which ones do you use and how often? _____

Are you allergic to any medicine? No Yes
If Yes, please list the medications you are allergic to and describe the reaction:

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 members suffer from psychiatric disorders? No Yes
If Yes, which family member and what condition(s)? _____

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 your drinking? Yes No
4. Have you ever had a drink first think in the morning to steady your nerves or get rid of a hangover (eye-opener)? Yes No

List All Medications	Info from home medication list (as identified from intake history, patient, family, prescription bottle)		
Drug Name	**Dose**	**Frequency**	**Route of Administration**

Please list any medications you took that FAILED to help give you relief:

Social History:

Are you: single, married, divorced, other (please circle one).

Do you reside in a: house, apartment, shared space, institution, no fixed address (please circle one).

Who lives with you? (Wife, husband, partner, no one) (please circle one).

If children are in your dwelling, please list them and their ages:

History of Operations-Surgeries/Trauma: Please list any surgery you have had and the year.

Psychological History: (Please circle applicable diagnosis below)

Do you suffer from: Anxiety Depression 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
If YES, Please provide date of last thought/Selfharm. _____
Please provide general explanation.
_____
_____

Are you often confused? No Yes

Review of Systems (If Yes, please explain)

Do you have any problems with 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 problems climbing stairs or exercising? 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

Pregnancy: 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 If yes, please indicate which joints or muscles are bothering you.

Do you have any swelling anywhere? No Yes

Signature of patient: _____