



## Green Valley Wellness - Our Process

Thank you for considering Green Valley Wellness. We are dedicated to assisting you with obtaining your legal authorization through the **Access to Cannabis for Medical Purposes Regulation (ACMPR)** under the *Cannabis Act* (Bill C-45).

As medical cannabis patients ourselves, we are aware of the difficulties that patients encounter when talking to their Doctors or Health Care Practitioners about *cannabis therapy*. Many patients, who are qualified to use medicinal cannabis, do not have authorization from their Health Care Practitioner to use this method of treatment despite legitimate reasoning. That is why we are here to help!

We keep our process as simple as possible for every patient across **Canada!**

Our initial consultation with our clinical educators, where we assess and determine your potential eligibility, is free. The initial consultation can be done via phone or in clinic during business hours, or via e-mail.

- ✓ During this initial consultation, our Patient Educators will:
  - Determine if you may be eligible for medicinal cannabis through the Cannabis Act
  - Provide educational information about cannabis
    - THC versus CBD
    - Sativa versus Indica versus Hybrid
    - Medical benefits
    - Etc

*Family physicians or attending medical healthcare professionals are welcome to provide relevant supporting medical documentation to ensure optimal treatment plans for the patient.*

Once the entirety of the application package has been completed, a patient may:

- ✓ **Drop-off** the application, and supporting medical documentation (*if applicable*), to their closest **Green Valley Wellness** clinic
- ✓ Scan the application package, and supporting medical documentation(*if applicable*), and **Email** it to [torontoeast@gvwellness.ca](mailto:torontoeast@gvwellness.ca)
- ✓ **Fax** or **Mail** the full application to your closest **Green Valley Wellness** clinic
- ✓ Each application must include a **COLOURED copy of valid GOVERNMENT ISSUED PHOTO IDENTIFICATION**
  - Driver's license, Passport, or Citizenship Cards.



There is a **package fee** including your consultations with our qualified **Health Care Practitioners** and **post-appointment services**. A deposit of 50% of the fee is required prior to the appointment, and the remaining balance is collected post-appointment. Please speak with a patient educator to determine which package is more suitable for your needs.

- ✓ Patients diagnosed with **Cancer, Fibromyalgia, CRPS**, and/or **MS**, and **Veterans, Seniors** and **First Responders** are exempt from small package assessment fees or subject to discounts for large package assessment fees.

Our **Health Care Practitioner** will then evaluate and review the application package and assess supporting medical documentation. Once approved, you will be contacted for an appointment date and time.

Once you have completed your appointments and are issued legal medical documentation, a patient educator will contact you. A clinical educator will provide you with next steps in the process: discuss Licensed Producers and the Cannabis Act Health Canada application.

- ✓ Patient educators will assist patients with the following:
  - **Cannabis Act Health Canada Application:** submission details, application process, etc.
  - Cannabis product education
  - Discuss dosage, titration, and treatment plans for each patient
  - Discuss Health Canada approved and regulated Licensed Producers within the Cannabis Act
  - Discuss how to obtain an ACMPR grow license for personal production of cannabis through Health Canada
  - Provide other wellness services offered at clinic location
- ✓ **Medical Documents** will be kept in clinic
- ✓ An **original copy** of your supporting document for your **Canada Act Health Canada** application will be given to you via mail or pick up, as Health Canada requires this original paperwork

**Please note:** If you need to cancel your appointment, please do so **24-48 hours** prior to your appointment. If not, cancellation fees will be applied for missed or cancelled appointments.

If you have any questions or concerns, please do not hesitate to contact your nearest Green Valley Wellness clinic. We are more than happy to help you!



Name as it appears on Health Card: \_\_\_\_\_

Date of Birth: MMM-DD-YYYY Address: \_\_\_\_\_

City: \_\_\_\_\_ Prov.: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email: \_\_\_\_\_ Skype Username: \_\_\_\_\_

How did you find out about our clinic? \_\_\_\_\_

Are you a Veteran?  Yes K#: \_\_\_\_\_

Are you a First Responder?  Yes

Will you be applying to Health Canada for your ACMPR license (“grow license”)?  Yes

Will you be using a ‘Designated Grower’?  Yes

### PATIENT MEDICAL INFORMATION

*Please feel free to include any medical documentation or other supporting document for your medical diagnosis*

Medical Diagnosis: \_\_\_\_\_

Requested Grams Per Day: \_\_\_\_\_

Do you plan on going to multiple Licensed Producers?  Yes

Licensed Producer(s): \_\_\_\_\_

### 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)					
<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	Difficulty Sleeping	<input type="checkbox"/>	Muscle Spasms
<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	Nausea
<input type="checkbox"/>	Back Pain	<input type="checkbox"/>	Foot Pain	<input type="checkbox"/>	Neck Pain
<input type="checkbox"/>	Chronic Pain	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	Constipation	<input type="checkbox"/>	Hip Pain	<input type="checkbox"/>	Shaking
<input type="checkbox"/>	Depression	<input type="checkbox"/>	Low Energy	<input type="checkbox"/>	Vision Issues
<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	Menstrual Pains	<input type="checkbox"/>	Weakness
<input type="checkbox"/>	Difficulty Eating	<input type="checkbox"/>	Mobility Issues	<input type="checkbox"/>	Weight Loss

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_



**Patient Consent to Disclose Personal Health Information (PHI) Form**

Name as it Appears on Health Card: \_\_\_\_\_

Date of Birth: MMM-DD-YYYY Address: \_\_\_\_\_

City: \_\_\_\_\_ Prov.: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

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: \_\_\_\_\_



## **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: \_\_\_\_\_

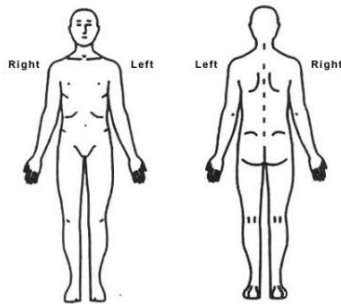
DATE SIGNED: \_\_\_\_\_ DATE SIGNED: \_\_\_\_\_

**Brief Pain Inventory**

1. Pain from time to time occurs (for example headaches, toothaches, sprains, etc). Have you experienced everyday pain not related to these common everyday pains?

Yes       No

2. Please indicate on the diagram the areas affect by pain



3. Please rate your pain by associating it to a number below that best describes the pain at its **worst** in the last 24hrs.

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 associating it to a number below that best describes the pain at its **best** in the last 24hrs.

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 associating it to a number below that best describes the 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 associating it to a number below that best describes the pain you're experiencing **right now**.

0 1 2 3 4 5 6 7 8 9 10  
No Pain Pain as bad as you can imagine

7. In the last 24hrs, using medication or treatment, how much relief have you experienced?

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

8. Please rate how your pain affects the following in the last 24hrs:

a) General activity

0 1 2 3 4 5 6 7 8 9 10  
No Pain Pain as bad as you can imagine

b) Mood

0 1 2 3 4 5 6 7 8 9 10  
No Pain Pain as bad as you can imagine

c) Walking ability

0 1 2 3 4 5 6 7 8 9 10  
No Pain Pain as bad as you can imagine

d) Normal work (outside/home/housework/etc)

0 1 2 3 4 5 6 7 8 9 10  
No Pain Pain as bad as you can imagine

e) Relationship with other people

0 1 2 3 4 5 6 7 8 9 10  
No Pain Pain as bad as you can imagine

f) Sleep

0 1 2 3 4 5 6 7 8 9 10  
No Pain Pain as bad as you can imagine

g) Enjoyment of life

0 1 2 3 4 5 6 7 8 9 10  
No Pain Pain as bad as you can imagine

h) Ability to concentrate

0 1 2 3 4 5 6 7 8 9 10  
No Pain Pain as bad as you can imagine

i) Appetite

0 1 2 3 4 5 6 7 8 9 10  
No Pain Pain as bad as you can imagine

9. In the area where you experience pain, do you have the sensation of 'pins and needle', tingling, prickling or any similar sensation?

Yes       No

10. Does the area you experience pain change in colour (mottled, redness, etc) when the pain is bad?

Yes       No



11. Does the pain you experience make the skin feel abnormally sensitive?

Yes       No

12. Does the pain you experience come in bursts when you are completely still?

Yes       No

13. Does the pain you experience feel hot or feel as if the skin is burning?

Yes       No

14. Gently rub the painful area and an area where you do not feel pain. How does the rubbing feel in the area of pain?

No Difference

Discomfort – sensation of pins and needles or tingling

15. Gently press on the area where you experience pain. How does this feel?

No Difference

Discomfort – sensation of pins and needles or tingling

### 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
<i>Add the score for each column</i>	+	+	+	
<b>Total Score (add your column scores) =</b>				

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 \_\_\_\_\_





**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 one(s) do you use, how often and what at dosage? \_\_\_\_\_

\_\_\_\_\_

Do you use cocaine or other "street" drugs?  No  Yes

If Yes, which one(s) 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

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 thing 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: \_\_\_\_\_

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**Social History:**

**Marital Status:**  Single  Married  Divorced  Other: \_\_\_\_\_

**Residential Status:**  House  Apartment  Institution  Shared Space

No Fixed Address

Please list who resides with you: \_\_\_\_\_

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

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

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### Psychological History

Do you suffer from:  Anxiety  Depression  Insomnia  Bipolar Disorder  OCD

What year(s) were you diagnosed with your illness? \_\_\_\_\_.

Have you been hospitalized for any of these illnesses?  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/Self harm. \_\_\_\_\_

Please provide general explanation: \_\_\_\_\_

Are you often confused?  No  Yes

### Review of Systems

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

Please indicate: \_\_\_\_\_

Do you have any swelling anywhere?  No  Yes

SIGNATURE: \_\_\_\_\_