GREEN VALLEY WELLNESS WHITBY
Unit 116-1910 DUNDAS ST E,
WHITBY, ONT, L1N 2L6
Phone: 905-571-0420
Fax: 905-571-0603
Email: info@gvwellness.ca

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 *info@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.

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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!

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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)**

☐	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:** _____

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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:** _____

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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.

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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: _____

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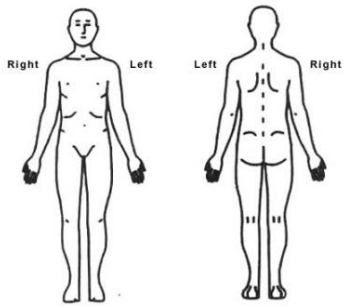
Brief Pain Inventory

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

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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
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.

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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**: _____

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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)? _____

_____

_____

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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:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other:_____

Residential Status: ☐ House ☐ Apartment ☐ Institution ☐ Shared Space ☐ No Fixed Address

Please list who resides with you: _____

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:_____

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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: _____