GREEN VALLEY WELLNESS WHITBY
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**

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- 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!

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PATIENT RENEWAL

Name as it appears on Health Card: _____

Date of Birth: _____MMM-DD-YYYY_____ **Address**:_____

City:_____ **Prov.**:_____ **Postal Code**:_____

Phone Number:_____

Email:_____ **Skype Username**:_____

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 INTAKE

Current Grams per Day:_____ **Would you like to increase your grams per day?** ☐ Yes

If 'Yes' what is your reasoning? _____

_____

If 'Yes' what would you like to request for your NEW grams per day?_____

Current Licensed Producer(s): _____

If you would like to switch license producer(s), please indicate new Licensed Producer request(s) here: _____

_____

Why would you like to switch Licensed Producers?_____

_____

_____

Medical condition(s) being treated by cannabis:_____

_____

_____

PATIENT SIGNATURE:_____ **DATE**:_____

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What is your preferred method of cannabis consumption?_____

Have you experienced any 'adverse reaction' to cannabis? ☐ **Yes** ☐ **No**

Please explain the adverse reaction:_____

Please list any medications you are taking:

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

Allergies:_____

Is there anything the health care practitioner should know, if so please list it:_____

PATIENT SIGNATURE:_____ **DATE:**_____

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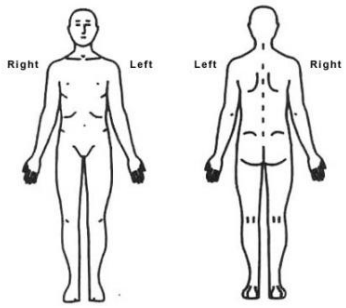
Brief Pain Inventory

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**: _____