PATIENT CONTACT INFORMATION

NAME: _____

MALE, FEMALE OR OTHER: _____

ADDRESS: _____

CITY & PROVINCE: _____

POSTAL CODE: _____

DATE OF BIRTH: _____

PHONE NUMBER: _____

EMAIL: _____

SKYPE USERNAME: _____

HEALTH CARD NUMBER: _____

PRIMARY DIAGNOSIS: _____

SECONDARY DIAGNOSIS: _____

ARE YOU LOOKING TO OBTAIN A SELF GROW LICENSE: _____

LICENSED PRODUCER (IF APPLICABLE): _____

REQUESTED GRAMS PER DAY: _____

FAMILY PHYSICIAN/SPECIALIST (IF APPLICABLE): _____

ADDRESS OF FAMILY PHYSICIAN/SPECIALIST: _____

Contact Information:
Phone: 1-833-CAN-THRV (226-8748) Email: info@cannathrive.ca
www.cannathrive.ca

Parent / Guardian Consent Form

Medical Cannabis

The long-term use of cannabis in patients under the age of 25 may be related to reducing neural development of the brain which has not fully developed until the age of 25 years old. By signing this consent both the patient and the parent acknowledge this fact.

_____ _____

Patient Name (Printed) **Patient Signature**

_____

Date

_____ _____

Parent/Guardian Name (Printed) **Parent/Guardian Name (Signature)**

_____ _____

Relationship to Patient (Printed) **Date**

Contact Information:
Phone: 1-833-CAN-THRV (226-8748) Email: info@cannathrive.ca
www.cannathrive.ca

CONSENT TO DISCLOSE PERSONAL INFORMATION (PHI) FORM

NAME: _____

DATE OF BIRTH: _____

PHONE NUMBER: _____

EMAIL: _____

ADDRESS: _____

I _____, consent to the release of personal health information (PHI) to 10322555 Canada Incorporated (Canna Thrive) by way of unsecured mail (Gmail, Hotmail, etc.). 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 NP Specialist to which I am having my medical assessment.

Initials: _____

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.

Initials: _____

I _____, authorize 10322555 Canada Incorporated (Canna Thrive), to share my personal health information with the Specialist/NP/Physician's clinic to which I wish to have an assessment and the Licensed Producer. The information may be used to contract, assess and register the patient and for the analysis and research to better help our patients. I also grant the Licensed Producer permission to disclose personal and sales related information to Canna Thrive, for tracking and information purposes.

Initials: _____

I _____, understand the purpose for disclosing this personal health information to 10322555 Canada Incorporated (Canna Thrive) and I understand that I can refuse to sign this form.

Initials: _____

I hereby release 10322555 Canada Incorporated (Canna Thrive), the assessing Physician/NP/Specialist, his/her clinic, my family Physician and any other involved Physicians from any and all actions, claims, causes of actions, complaints (even by family & 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 Medical Cannabis.

Initials: _____

Canna Thrive may collect, use, share and access different types of information or data about the company's patients in such ways that do not identify such individuals directly (e.g. by name) or indirectly (e.g. by date of birth) and for statistical purposes only. Such information may include personal characteristics or other information about which an individual has a reasonable expectation of privacy (e.g., age, ethnicity, health history, life experience, social status). The company does not release any information that could identify individuals without their consent. I certify that the information on this form and in connection with my registration is true and accurate. I acknowledge that I am responsible for the information that I provided and any costs associated with providing false information.

Initials: _____

Signature: _____

Date: _____ / _____ / _____

RELEASE ACKNOWLEDGEMENT & INDEMENITY FOR PATIENTS SEEKING AN ACMPR MEDICAL DOCUMENT

I_____, understand that the information I have been asked to provide to Canna Thrive and/or the consulting Physician is for the diagnosis and treatment of the medical condition(s) for which I want to access to medical cannabis. I understand that if I have not accurately and completely disclosed the requested information, it may adversely impact the Physician's ability to diagnosis my condition and recommend appropriate Medical Cannabis treatment.

Initials: _____

I_____, understand that this RELEASE & ACKNOWLEDGEMENT contains valuable information about possessing/cultivating and consuming prescribed Medical Cannabis, for medical purposes regulations (ACMPR). I also understand that the consulting Specialist/NP/Physicians will not necessarily be assuming primary care for me, but only be recognized that the consulting, Specialist/NP/Physician will not necessarily be assuming primary care for me, but only recognized as my ACMPR prescribing Physician/NP/Specialist. I understand and agree to continue to regularly visit with my primary care Physician for my medical conditions on a regular basis and notify them of my medical use of Medical Cannabis.

Initials: _____

The Specialist/NP/Physicians will weigh the risk versus the rewards in treating my medical condition(s) and their symptoms associated with Medical Cannabis. I confirm that the Specialist/NP/Physicians 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 the assessing Specialist/NP/Physicians**,** 10322555 Canada Incorporated (Canna Thrive), my family Physician or any other involved Physician in regard to:

A) **My consumption of Medical Cannabis; and**
B) **My Application or Medical Document(s) for possessing, obtaining, cultivating and consuming Medical Cannabis.**

I am aware that the Specialist/NP/Physician's generally agrees that Medical Cannabis:

May affect sight, sounds and touch – May impair thinking, problem solving, coordination, memory and learning

May increase hearth rate and reduce blood pressure

May induce anxiety, fear, distrust or panic attacks

Initials: _____

RELEASE ACKNOWLEDGEMENT & INDEMNITY PATIENTS SEEKING AN ACMPR MEDICAL DOCUMENT

I am aware that medical conditions such as schizophrenia, atrial fibrillation; heart attack/strokes or use of blood thinners may result in denial for 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.

Initials: _____

I am aware that Canna Thrive's job is **COMPLETE** once I receive my Medical Document from the Health Care Practitioner. I also understand that there is a waiting time with Health Canada to apply for a grower certificate which Canna Thrive is not responsible for.

Initials: _____

This release for liability is to be binding on heirs, executors & my signatures. I acknowledge I have the right to refuse to sign this document.

Initials: _____

PATIENT PRINT NAME

PRINT NAME: _____

SIGNATURE: _____

DATE: _____

WITNESS PRINT NAME

PRINT NAME: _____

SIGNATURE: _____

DATE: _____

Contact Information:
Phone: 1-833-CAN-THRV (226-8748) Email: info@cannathrive.ca
www.cannathrive.ca

NAME: _____ DATE: _____

ADDRESS: _____ DOCTOR'S NAME: _____

CITY/PROV: _____ REFERRED BY: _____

PHONE: _____ BIRTH DATE: _____

OCCUPATION: _____

MEDICAL CANNABIS ASSESSMENT

Primary medical problem for which Cannabis is being requested: _____

What year did medical problems commence? _____ (Year)

What (physically) makes the symptoms worse?

_____

_____

What can you do (physically) to feel better? (If anything)

_____

_____

Are there any secondary medical problem(s)? **NO** **YES** (Circle One)

If **YES**, please list the diagnoses:

_____

Do you currently use Cannabis for relief? **NO** **YES** – Smoke, Vapor, Edible, Topical, Oils?

If **YES** above, how many times a day do you use it? _____

Contact Information:
Phone: 1-833-CAN-THRV (226-8748) Email: info@cannathrive.ca
www.cannathrive.ca

When did you last use it? _____ How long have you used it medically? _____

If **YES**, do you obtain it from a legal source? **NO** **YES** (Circle One)

If you do not obtain a prescription Cannabis, will you continue to use it? **NO** **YES** (Circle One)

Do you smoke tobacco? **NO** **YES** (Circle One) – (Cigarettes, Pipe, Cigars) ____ per day.

Do you drink alcohol? **NO** **YES** (Circle One) – (Beer, Wine, Spirits) ____ drinks per day.

Do you use medicines containing opiates? (Codeine, Morphine, Other) **NO** **YES** (Circle One)

If **YES**, which ones do you use and how often and what dosage?

_____

_____

History of operations/surgeries: (Please list any surgery you have had and the year)

_____

_____

_____

_____

Psychological History (Please circle 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** (Circle One) - _____ (Year)

Have you had any thoughts of self-harm or suicide? **NO** **YES** (Circle One)

_____

_____

REVIEW OF SYMPTOMS

Do you have any problems with senses? (Sight, Smell, Taste, Hearing, Touch) **NO** **YES**

Do you have any problems with your head or neck? **NO** **YES**

Do you have problems with breathing or lung diseases? **NO** **YES**

Do you have heart or circulation problems? **NO** **YES**

Do you have problems climbing stairs or exercising? **NO** **YES**

Do you have any eating, swallowing, digestion or any problems with your bowels? **NO** **YES**

Do you have any problems with your kidneys, bladder or problems with urination? **NO** **YES**

Do you use cocaine or other "street" drugs? **NO** **YES** (Circle One)

If **YES**, which ones do you use and how often?

_____

Are you allergic to any medicine(s)? **NO** **YES** (Circle one)

If **YES**, list the medications you are allergic to:

_____

_____

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**

_____

Medications (Please list your current prescription medications (if any), the doses, times taken and provide a list **printed** at your medical pharmacy)

_____

_____

Please list any medications you have previously taken that FAILED to give you relief:

_____

_____

Social History: **SINGLE** **MARRIED** **DIVORCED** **OTHER** (Circle One)

Dwelling: **HOUSE** **APARTMENT** **SHARED SPACED** **INSITITUTION** **NO ADDRESS** (Circle one)

Who lives with you? **WIFE** **HUSBAND** **PARTNER** **NO ONE** (Circle One)

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

_____

_____

Pregnancy: Are you pregnant now or might you become pregnant in the near future? **NO** **YES** (Circle One)

Do you have problems with your muscles or joints? **NO** **YES** (Circle One)

If **YES**, please indicate which joints or muscles you are having problems with:

_____

_____

General: **HEIGHT: _____** **WEIGHT: _____**

Are you in any distress now? **NO** **YES** (Circle One)

If **YES**, please describe:

_____

_____

Do you feel comfortable now? **NO** **YES** (Circle One)

Are you aware of the date, time and current location? **NO** **YES** (Circle One)

Are you often confused? **NO** **YES** (Circle One)

If you drive a vehicle on the road or operate machinery, **DO NOT DO SO:**

1. Within 4 (FOUR) Hours of inhaling Cannabis vapor 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 medicine in a LOCKED BOX.

SIGNATURE OF PATIENT: _____

Assessment:

_____

_____

_____

Plan:

_____

_____

_____

CONSENT TO USE ELECTRONIC COMMUNICATIONS

NAME: M******* B*******

PROFESSION: N**** P**********

ADDRESS: 1**-1** S****** R***

P**** O******, H** 3**

PHONE: 1-855-***-****

FAX: 1-855-***-****

SKYPE: ****-****

The Physician/Nurse Practitioner has ordered to communicate using the following means of electronic communications (the services):

Videoconferencing – SKYPE

PATIENT ACKNOWLEDGEMENT AND AGREEMENT

I acknowledge that I have read and fully understand the risks, limitation, conditions of use and instructions for use of the selected electronic communication services more fully described in the Appendix to this consent form. I understand and accept the risk outlined in the Appendix as well any other conditions that the Physician may impose on the communications with patients using the services.

I acknowledge and understand and that despite recommendations that encryption software be used as a security mechanism for electronic communications, it is possible that communications with Physician or the Physician's staff using these services with the full understanding of the risk.

I acknowledge that either I or the Physician can at any time withdraw the option of communication electronically through the services upon providing written notice.

PATIENT INFORMATION

NAME: _____

ADDRESS: _____

DATE OF BIRTH: _____

PHONE: _____

SKYPE USERNAME: _____

SIGNATURE: _____ DATE: _____ / _____ / _____

WITNESS SIGNATURE: _____ DATE: _____ / _____ / _____

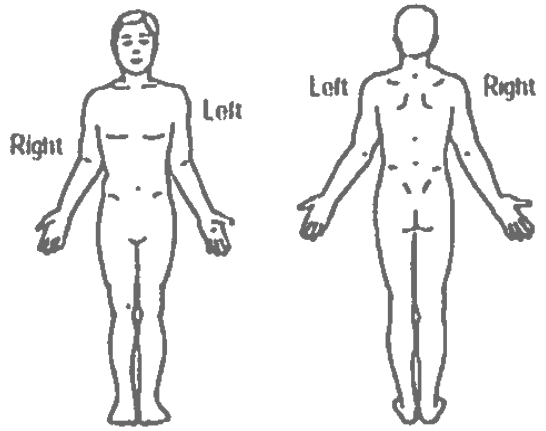
Date Time

Name
Last First Middle initial

1) Throughout our lives, most of us have had pain from time t time such as minor headaches sprains and toothaches Have you had pain other than these everyday kinds of pain today?

1 Yes N

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



) Please rate your pain by circling the one number that best describes your pain at its **worst** in the past 24 hour

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 ircling the no number that best describes your pain at its **least** in the past 24 hour

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

Please rate your pain by ircling the ne 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

) Please rate your pain by circ ing the one number that tells 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

7) What treatments or medications are you receiving for your pain

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

10 20 30 40 50 60 70 80 90 100%
No relief — Complete relief

ir . the one number that describes how during the past 4 hours, pain has **interfered** with your

A General activity

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

B Mood

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

Walking ty

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

D. Normal work (includes both work outside the home and housework)

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

E. Relations with other people

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

F. Sleep

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

G. Enjoyment of life

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

Date _____

Patient Name _____

OPIOID RISK TOOL©

		Mark each box that applies	Item Score If Female	Item Score If Male
1. Family History of Substance Abuse	Alcohol	[ ]	1	3
	Illegal Drugs	[ ]	2	3
	Prescription Drugs	[ ]	4	4
2. Personal History of Substance Abuse	Alcohol	[ ]	3	3
	Illegal Drugs	[ ]	4	4
	Prescription Drugs	[ ]	5	5
3. Age (Mark box if 16 – 45)		[ ]	1	1
4. History of Preadolescent Sexual Abuse		[ ]	3	0
5. Psychological Disease	Attention Deficit Disorder Obsessive Compulsive Disorder Bipolar Schizophrenia	[ ]	2	2
	Depression	[ ]	1	1
TOTAL		[ ]		

Total Score Risk Category Low Risk 0 – 3 Moderate Risk 4 – 7 High Risk ≥ 8

Hospital Anxiety and Depression Scale

~ Scoring Sheet ~

	Yes definitely	Yes sometimes	No, not much	No, not at all
1. I wake early and then sleep badly for the rest of the night.	3	2	1	0
2. I get very frightened or have panic feelings for apparently no reason at all.	3	2	1	0
3. I feel miserable and sad.	3	2	1	0
4. I feel anxious when I go out of the house on my own.	3	2	1	0
5. I have lost interest in things.	3	2	1	0
6. I get palpitations, or sensations of 'butterflies' in my stomach or chest.	3	2	1	0
7. I have a good appetite.	0	1	2	3
8. I feel scared or frightened.	3	2	1	0
9. I feel life is not worth living.	3	2	1	0
10. I still enjoy the things I used to.	0	1	2	3
11. I am restless and can't keep still.	3	2	1	0
12. I am more irritable than usual.	3	2	1	0
13. I feel as if I have slowed down.	3	2	1	0
14. Worrying thoughts constantly go through my mind.	3	2	1	0

Anxiety 2, 4, 6, 8, 11, 12, 14

Depression 1, 3, 5, 7, 9, 10, 13

Scoring 3, 2, 1, 0 (For items 7 & 10 the scoring is reversed)

GRADING: 0 - 7 = Non-case 8 – 10 = Borderline case 11+ = Case

MISSED APPOINTMENT AGREEMENT

It is very important that each patient attends his or her scheduled appointments. If you are unable to make a previously booked appointment, please provide at least 24 hours' notice of cancellation so your appointment can be given to another patient.

If appointments are missed without 24 hours' notice, you will be charged a $50.00 fee, which is due in full before a new appointment time will be scheduled. If a 2nd appointment is missed without 24 hours' notice for the cancellation, you will be charged a $75.00 fee which is due in full before another appointment will be scheduled.

By signing below, I, _____, understand that:

1) I must provide at least 24 hours' notice of a doctor's appointment cancellation or I will be charged a $50.00 fee for missing a doctor's appointment without providing 24 hours' notice
2) I will be charged a $75.00 fee for the second missed doctor's appointment without calling to cancel the appointment 24 hours in advance
3) The fee for missing an appointment is due in full prior to another doctor's appointment being scheduled

SIGNATURE OF PATIENT: _____

280-3 Hamilton Rd
London,ON
N5Z 1R3
1 - (833) - 226- 8478
CannaThrive.ca
info@cannathrive.ca

CONSENT TO DISCLOSE PERSONAL INFORMATION TO CANNA THRIVE and the patients chosen Licensed Producer.

Pursuant to the Personal Health Information Protection Act, 2004 (PHIPA)

I ,_____, authorize Canna Thrive to disclose and discuss my personal information consisting of:

Medical Document(s) and Registration Form(s) to be transmitted by CANNA THRIVE.

I understand the purpose for disclosing this personal information to the person noted above.

I understand that I can refuse to sign this consent form.

As per PHIPA requirements consent must be defined for a definite period. This consent is valid for the duration of the Medical Document submitted by the Client.

CLIENT INFORMATION

Name: _____ Telephone Number: _____

Address: _____

Driver's License Number (E.G. K 123456789): _____

Signature: _____ Date: (DD/MM/YYYY): _____