PATIENT CONTACT INFORMATION

NAME: _____

OCCUPATION: _____

GENDER: MALE , FEMALE , Other : _____

DATE OF BIRTH: _____

ADDRESS: _____

CITY & PROVINCE: _____

POSTAL CODE: _____

PHONE NUMBER: _____

EMAIL: _____

HEALTH CARD NUMBER: _____

PRIMARY DIAGNOSIS: _____

SECONDARY DIAGNOSIS: _____

LICENSED PRODUCER REQUESTED: _____

REQUESTED GRAMS PER DAY: _____

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 $75.00 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 $100.00 fee which is due in full before another appointment will be scheduled. If a 3rd appointment is missed, you will not be scheduled again.

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 $75.00 fee for missing a doctor's appointment without providing 24 hours' notice
2) I will be charged a $100.00 fee for the second missed doctor's appointment without calling to cancel the appointment 24 hours in advance
3) If a 3rd appointment is missed, I will not be scheduled again
4) The fee for missing an appointment is due in full prior to another doctor's appointment being scheduled

SIGNATURE OF PATIENT: _____

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

PARENT GUARDIAN CONSENT

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**

CONSENT TO DISCLOSE PERSONAL INFORMATION (PHI) FORM

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: _____

10322555 Canada Incorporated (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: _____

Patient Signature: _____ Date: _____

RELEASE ACKNOWLEDGEMENT & INDEMNITY 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 (ACMPR). I also understand that the consulting Specialist/NP/Physicians will not necessarily be assuming primary care for me, but will only be 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 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 FOR 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	**WITNESS PRINT NAME**
PRINT NAME: _____	PRINT NAME: _____
SIGNATURE: _____	SIGNATURE: _____
DATE: _____	DATE: _____

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**

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

_____

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

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? _____

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**

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

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

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

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

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

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 - _____ (Year)

Have you had any thoughts of self-harm or suicide? **NO** **YES**

_____

_____

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**

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

_____

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

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.) – **Your pharmacy should keep an updated record.**

_____

_____

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

_____

_____

Social History: **SINGLE** **MARRIED** **DIVORCED** **OTHER:** _____

Dwelling: **HOUSE** **APARTMENT** **SHARED SPACED** **INSTITUTION** **NO ADDRESS**

Who lives with you? **WIFE** **HUSBAND** **PARTNER** **NO ONE** **FRIENDS**

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**

Do you have problems with your muscles or joints? **NO** **YES**

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

_____

_____

Are you in any distress now? **NO** **YES**

If **YES**, please describe:

_____

_____

Do you feel comfortable now? **NO** **YES**

Are you aware of the date, time and current location? **NO** **YES**

Are you often confused? **NO** **YES**

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: _____X

CANNA THRIVE MEMBERSHIP AGREEMENT

This agreement is dated _____.

Operating as CANNA THRIVE is entering a membership contract with member _____.
(NAME)

CANNA THRIVE MEMBERSHIP:

1. CANNA THRIVE will prescreen ALL membership applications through the application package provided and pre-consultation process. CANNA THRIVE will perform our preliminary assessment on the chances of you receiving legal medical access. Your application WILL NOT BE FORWARDED if we believe that you have no chance of being approved for medical cannabis.
2. ANY Membership fees are due and payable immediately upon completing our preliminary assessment if you wish to submit your application.
3. CANNA Thrive has the right to cancel your script if you are not ordering from your Licensed Producer if you exceed 3 months consecutively of not ordering.
4. CANNA THRIVE will arrange a private and confidential meeting by electronic means between the member and a highly qualified medical practitioner authorized to approve or decline your use of medical cannabis.
5. CANNA THRIVE CANNOT GUARANTEE UNDER ANY CIRCUMSTANCES that a member shall be approved for a Medical Document.
6. If a member is not approved for a Medical Document the membership fee would be refunded in the amount of 75% of the total membership cost.
7. CANNA THRIVE will provide ongoing advice regarding Canada's top LP's (Licensed Producers) and the most appropriate strains of medical cannabis for your condition.
8. Members are eligible for discount products in our shop as they become available.
9. Members receive 24 hours / 7 days a week emergency access to assistance if police or authorities require verification of the Medical Document.
10. CANNA THRIVE will keep you organized with renewal reminders.
11. All medical information shall be kept in the strictest confidence. CANNA THRIVE will NEVER sell or allow access to the membership roster except on orders of the police with a court-issued warrant.

Membership Obligations

12. By signing this application, CANNA THRIVE members undertake to be honest and forthright regarding their medical condition when preparing the patient assessment, during the medical assessment, and must openly disclose all other prescription and non-prescription medications to the physician.
13. By signing this application CANNA THRIVE members acknowledge that violation of the physician-patient contract shall immediately terminate this contract.
14. By signing this application CANNA THRIVE members acknowledge that they are solely responsible for any violation of The Criminal Code or the Controlled Drugs and Substances Act.

PATIENT PRINT NAME **WITNESS PRINT NAME**

PRINT NAME: _____ PRINT NAME: _____

SIGNATURE: _____ SIGNATURE: _____

DATE: _____ DATE: _____

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: _____
E-mail Address: _____

SIGNATURE: _____ DATE: _____

WITNESS SIGNATURE: _____ DATE: _____