NEW PATIENT FORM: Approval/Denial into our Medical Cannabis Program is based on your face to face encounter

DEMOGRAPHIC INFORMATION

Please complete every section to prevent delay in being added to the registry.

Last Name _____ First Name _____ M.I._____

DOB ___/___/____ SS # ____-____-_____ Gender Female Male Wt. ____ lbs.

Primary Phone _____

Email Address_____@_____

Address _____

City _____ Zip _____ County _____

Emergency Contact _____ Phone _____

Relationship _____

Are you pregnant or planning pregnancy? (CIRCLE) Yes No

Are you in a substance abuse program? (CIRCLE) Yes No

ADDITIONAL INFORMATION

Note: Your Social Security Number (SSN) is required to add you to the Florida Registry.

(Optional) Legal Representative, for the Registry: Name_____

Relationship to Patient _____

Birth Date ____/_____/_____ Soc. Sec.(SSN) _ _ _ - _ _ -_ _ _ _

Address (if different from patient's) _____

City _____ State _____ Zip __ County_____

Phone_____ E-mail address_____@_____

PRIMARY CARE PHYSICIAN NAME _____

Phone_____

Address _____

City_____ State_____ Zip _____

REFERRING PHYSICIAN(S) INFORMATION

	PAIN DOCTOR	PSYCHIATRIST	NEUROLOGIST	ONCOLOGIST	SURGEON/OTHER
DOCTOR NAME					
OFFFICE PHONE:					

CONSENT TO TREAT NOTE:
You are <u>not eligible</u> for this program if you are pregnant, planning pregnancy, or breastfeeding.

I (or my authorized representative on my behalf) hereby consent and authorize MEDICAL CANNABIS TREATMENT CENTER OF HOLLYWOOD and other staff members involved in my care to administer such diagnostic tests or treatments as they may consider advisable to assess, evaluate and treat my symptoms or illness and to improve or maintain my health. I understand that the provider responsible for my care has the responsibility to explain to me the purpose, the benefits and the most common risks involved in the diagnosis and treatment of my illness or symptoms, as well as alternative available courses of treatment, and I understand that I have the right to refuse any suggestions, tests or treatments. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment. Risk is not limited to infection, drug reactions, death.

_____ _____ _____

Date Patient Signature

Name: _____	
Chief Complaint (Debilitating Condition) (Circle all that apply)	
Cancer: Primary: _____Stage: Epilepsy, Glaucoma, Positive status for HIV/AIDS	Spasms, PTSD, Anxiety, Amyotrophic lateral sclerosis (ALS), Crohn's Disease, Parkinson's Disease, Multiple Sclerosis, Autism
Or other debilitating medical conditions of the same kind or class as or comparable to those enumerated, and for which the referring physician believes that the medical use of marijuana would likely outweigh the potential health risks for a patient: (Circle): Debilitating Pain (due to injury and/or degeneration of the spine, joints, or nerves).	
In your own words, please briefly describe the debilitating condition:	
Which physician diagnosed the condition?	When?

List of symptoms:

Symptom	Frequency of onset	Severity	Duration
	Constant - Intermittent	Mild - moderate - severe	
	Constant - Intermittent	Mild - moderate - severe	
	Constant - Intermittent	Mild - moderate - severe	

Prior treatment(s), how long was each treatment attempted, and outcomes of each

Prior Treatment	Outcome of Treatment	Prior Treatment	Outcome of Treatment
1.		4.	
2.		5.	
3.		6.	

Social History

Do you consume alcohol?	Yes	No	If Yes, how often?
Do you smoke?	Yes	No	If Yes, how much per day?
Do you use Illicit Drugs	Yes	No	If yes, what type(s) and how often?
Do you have a criminal record?	Yes	No	If Yes, please explain?

Co-morbidities/disease history (circle all that apply)

weight loss, hepatitis, rheumatic fever, mono, flu, arthritis, Ca, gout, asthma/COPD, pneumonia, thyroid dx, blood dyscrasias, ASCVD, HTN, UTIs, DM, seizures, operations, injuries, PUD/GERD, psych hx, OTHER:

Hospitalizations

Do you have any drug allergies: YES NO. If YES, list Allergies and reaction(s) below

Current Medications

Psychoactive (anxiety, anti-depressants, anti-psychotic, sleep, or stimulants.)

Medication Name	Dose	How Often?	For What Condition?

Other Medications including pain medication:

Medication Name	Dose	How Often? (ex twice daily)	Target Symptoms

OTC/Supplements/Herbals/Other Self-Medication:

Medication Name	Dose	How Often?	Target Symptoms

What is your main goal for treatment with cannabis? _____
For how long ? _____

Have you had a previous Face to Face encounter with the provider? Yes / No

- If yes, when: < 1 month ago 1-3 months ago or > 3mos (90 days)