hybridpharm

PATIENT REGISTRATION Form

318 Richmond Road – Ottawa, ON – K1Z 6X6
p: 613-695-4923 f: 343-888-2004 e: info@hybridpharm.com

PATIENT INFORMATION

Are you applying for: ☐ Myself
☐ I am a caregiver

First Name(s): _____ Last Name: _____

Birth Date: [M]_____ [D]_____ [Y]_____ Gender: ☐ Male ☐ Female ☐ N/A

Phone #: _____ Email: _____

How would you like to be contacted? ☐ Email ☐ Phone ☐ Text @: _____

I consent to receiving e mail communication from Hybrid Pharm: ☐ Yes ☐ No

(Emails we may send you will include news updates from Hybrid Pharm, appointment reminders and consultation reports
We will not spam you and you can unsubscribe at anytime.)

CAREGIVER INFORMATION (IF APPLICABLE)

First Name(s): _____ Last Name: _____

Birth Date: [M]_____ [D]_____ [Y]_____ Gender: ☐ Male ☐ Female ☐ N/A

Phone #: _____ Email: _____

How would you like to be contacted? ☐ Email ☐ Phone ☐ Text @: _____

ADDRESS

Address type: ☐ Private ☐ Establishment (nursing home, hospice, hospital) Name: _____

Address: _____ City: _____ Postal Code: _____ Province: _____

HEALTH INFORMATION

Health Card #: _____ *(Veterans please enter K#) Exp:* _____

Drug Allergies: ☐ NKDA
☐ Yes (please specify): _____ _____
_____ _____

(Please complete reverse side of form)

Are you currently taking any medications (including prescriptions and over the counter)? ☐ Yes ☐ No

If yes, Please list:

_____ _____

_____ _____

_____ _____

PATIENT / CAREGIVER / RESPONSIBLE PERSON CONSENT

☐ The patient/caregiver is a permanent resident of canada.

☐ The information in this form is complete and accurate.

☐ The applicant will use medical cannabis only for their own medical purposes.

The undersigned, being an individual authorized to possess and consume cannabis for medical purposes pursuant to the Cannabis Regulations, SOR/2018-144, or the parent, legal guardian or responsible person for _____ (the "Client"), acknowledges that cannabis is not the equivalent of a prescription drug, even when it is used for medical purposes. Health Canada states that there is only some evidence of potential therapeutic uses for cannabis or its component chemicals (called cannabinoids, e.g. THC and CBD). Health Canada advises the public that determining whether cannabis is appropriate to treat a medical condition and the symptoms of a medical condition is best done through a discussion with a healthcare practitioner (a medical doctor or nurse practitioner). Hybrid Pharm supports and affirms Health Canada's positions regarding the use of cannabis for medical purposes.

The indications, safety and risks of the use of cannabis for medical or other purposes have not been adequately studied and precise dosing, dosages and dosage forms remain unclear. The Client or the undersigned for and on behalf of the Client acknowledges and agrees that the Client will be using cannabis for medical purposes at the Client's own risk and the Client or the undersigned personally and on behalf of the Client releases Hybrid Pharm Inc. (and all its directors, officers, employees, subsidiaries and related parties) from any and all actions, claims, complaints and demands for damages, loss or injury arising directly or indirectly from the use of medical cannabis by the Client that has been obtained from Hybrid Pharm Inc. or any related sources.

Health Canada advises the public of the following potential negative outcomes of the consumption of cannabis:

1. Short-term negative effects of cannabis may include:
    a. Impair one's ability to drive safely or operate equipment by slowing reaction times, lowering one's ability to pay attention and harm coordination;
    b. Make it harder to learn and remember things;
    c. Affect mood and feelings and can cause anxiety or panic; and
    d. Affect mental health including triggering a psychotic episode.
2. Long-term effects of cannabis may include:
    a. Depending on the manner in which cannabis is consumed, damage to lungs and make it harder for someone to breathe;
    b. Affect and worsen mental health and may make it more likely to experience anxiety, depression, psychosis and schizophrenia;
    c. Make someone physically dependent on or addicted to cannabis especially if it is used regularly.

The undersigned, on behalf of the Client acknowledges these possible negative outcomes of the Client's use of cannabis and believes that the benefits of the Client using cannabis for medical purposes outweighs the said risk(s).

For further information regarding Health Canada's advisories regarding cannabis use for medical purposes and the risks associated with such use, the undersigned is advised to consult Health Canada's website regularly.

In order for the Client to receive cannabis products and related services, the Client or the undersigned personally and on behalf of the Client authorizes and consents to Hybrid Pharm disclosing any and all necessary information of the Client and/or the undersigned to third parties, including licensed producers, healthcare practitioners and other related parties by phone, physical or digital means or other means of communication.

In situations where "telemedicine" is used to conduct consultations with a healthcare practitioner, the Client or the undersigned on behalf of the Client acknowledges and agrees that telemedicine is an appropriate and adequate method of receiving health care advice for their circumstances, and understands that potentially sensitive health information will be communicated electronically. The Client or the undersigned on behalf of the Client understands it is their responsibility to undertake appropriate measures to ensure that they are conducting the consultation with a healthcare practitioner via telemedicine in a private and secure area. The Client or the undersigned on behalf of the Client acknowledges that despite reasonable efforts by Hybrid Pharm to protect their privacy and to prevent the loss of sensitive information via electronic communications, situations may arise leading to this due to technical failures of software, hardware, internet service providers or by human error. The Client or the undersigned on behalf of the Client agrees to inform Hybrid Pharm and its representatives in advance of any information that they do not wish to share electronically, and acknowledges that they are aware that in person consultations with a healthcare practitioner are available throughout the Greater Ottawa area.

SIGNATURES:

PATIENT:

Printed Name: _____

Signature: _____

Date Signed (M/D/Y)**:** _____

PARENT/GAURDIAN/RESPONSIBLE PERSON:

Printed Name: _____

Signature: _____

Date Signed (M/D/Y)**:** _____

Relationship to Patient: _____

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PATIENT RELEASE Form

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TREATMENT AGREEMENT BETWEEN HEALTH PRACTITIONER & PATIENT

I understand that this Release and Acknowledgement contains IMPORTANT information about medical cannabis that the assessing physician requires that I acknowledge and understand before he/she may issue a prescription and/or authorization for use of medical cannabis.

I further understand that the consulting physician will not necessarily be assuming care for me. He/She will, however, assess and_ evaluate the appropriateness of my request to use medical cannabis to assist in treating the conditions and associated symptoms that I believe; from my own personal experience medical cannabis to be helpful in treating.

I accordingly confirm that the assessing physician will be my medical practitioner for the sole purpose of medical cannabis authorization and/or prescriptions.

I agree not to make any claim or commence any legal proceedings against the assessing physician, his/her practice, my family physician or any other involved physicians (such as specialists) in relation to:

a) My use of cannabis as a medicine; and

b) My Application, or, prescription for possessing, obtaining, and using medical cannabis.

I am well aware that physicians generally agree that medical cannabis:

- May distort perception (sight, sounds, time, touch)
- May impair memory and learning
- May impair coordination (Avoid driving for 4 hours after smoking and 8 hours after ingesting)
- May impair thinking and problem-solving
- May increase heart rate and reduces blood
- May produces anxiety, fear, distrust, or panic

I am well aware there is considerable debate and a great lack of consensus among physicians about:

- The appropriate medical use of cannabis
- The appropriate dosage for medical cannabis
- The risks of smoking medical cannabis as compared to vaporizing or ingesting medical cannabis
- The risks of smoking whole plant medical cannabis as compared to extracting the medicinally active cannabinoids and medicating with same;
- The long-term health and psychological risks associated with the use of medical cannabis
- The degree to which regular consumption of medical cannabis:

a. May contribute to pulmonary infections and respiratory cancer
b. May damage the cells in bronchial passages which protect the body against inhaled microorganisms and decrease the ability of the immune cells in the lungs to fight off fungi, bacteria, and tumor cells. For patients with already weakened immune systems, this means an increase in the possibility of dangerous pulmonary infections, including pneumonia
c. May weaken various natural immune mechanisms, including macrophages and T-cells
d. May correlate in some cases with mental illness, such as bipolar disorder and schizophrenia

I am further well aware that the above listed medical concerns are further compounded by the lack of consistency and uniformity in available medical cannabis products. With conventional drug products I generally consume a medication of a precisely known molecular quantity. I recognize that raw plant Medical Cannabis does not work this. way. I appreciate that I will get varying compositions of different cannabinoids and varying proportions of different cannabinoids from strain of plant to strain of plant and even, to a lesser degree, from plant to plant of the same strain.

I further appreciate that there is a significant uncertainty regarding the consistency of the medical cannabis drug product I may medicate with which further complicates and compounds the practical issue of medicating with an inconsistent drug product like medical cannabis.

I am further aware that ingesting a high dose of medical cannabis can cause nausea and disorientation.

In seeking medical cannabis treatment and I confirm I have consulted with a physician regarding alternative and conventional treatment options for my condition.

_____
INITIALS

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Form

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TREATMENT AGREEMENT BETWEEN HEALTH PRACTITIONER & PATIENT CONT.

Despite all these medical concerns, debates and practical issues I honestly believe that for the treatment of my condition(s) and symptom(s) the benefits of medicating with medical cannabis outweigh the risks.

I agree to receive a “medical document” (ie prescription) for medical marijuana only from one physician.

I agree to purchase my marijuana only from a licensed producer. I am aware that possession of marijuana from other sources is illegal.

I agree to safely store my marijuana so that no other person can access it either deliberately or accidentally. I am aware that young people (under 25) may experience psychosis after consuming marijuana and will ensure that no child or young person will be exposed to my medical marijuana either directly or indirectly. I will contact Poison Control immediately if any child gains access to my supply of medical marijuana.

I am aware that taking marijuana with other substances, especially sedating substances, may cause harm and possibly even death. I will not use illegal drugs (eg, cocaine, heroin) or controlled substances (eg, narcotics, stimulants, anxiety pills) that were not prescribed for me.

I will inform the doctor of all controlled substances that are prescribed to me by my regular doctor(s). I will inform my primary care physician that I am being prescribed medical marijuana. I agree to have a medical assessment performed by my regular doctor at least every 12 months.

I am aware that marijuana use is not advisable during pregnancy and breastfeeding. I agree to inform my physician, if I am pregnant. If I become pregnant while being treated with medical marijuana, I will immediately stop using it until I have consulted with a physician.

This is my decision and I also do not support any claims made by my family, friends or other interested parties against said clinic and physicians.

I hereby release Hybrid Pharm, the assessing physician, his/her clinic, my family physician, and any other involved physicians 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 posses medical cannabis.

This release from liability is to be binding on heirs, executors and assigns. I also consent to the disclosure, sharing and use of my personal information and medical data by the assessing physician, Hybrid Pharm and my licensed commercial producer. The information may be used to contact, assess and register the patient and for analysis and research to better help our members.

I understand and acknowledge that while the assessing physician may execute a declaration that I stand to potentially benefit from medical cannabis, the assessing physician will not serve as my primary care physician. As such I agree to seek regular medical care from my primary care physician and that the assessing physician will only deal with assessing his support for my medical cannabis use. I also consent to the assessing physician notifying any specialists have seen of my decision to use medical cannabis and I accept any consequences of such notification.

I agree to notify my primary care physician myself about my intent to use cannabis medicinally as cannabis can interact with other medications. If licensed, I agree not to resell or give away any of my medication. I agree to check with local bylaws in my area. I also agree that any legal actions will lake place in Ontario and be governed by the laws of Ontario, Canada.

SIGNATURES:

Patient Name: _____ **Health Practitioner Name:** _____

Patient Signature: _____ **Health Practitioner Signature:** _____

Date Signed (M/D/Y): _____ **Date Signed** (M/D/Y): _____

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.

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**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 __0__ **+** _____ **+** _____ **+** _____

=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**
☐	☐	☐	☐

BRIEF PAIN INVENTORY

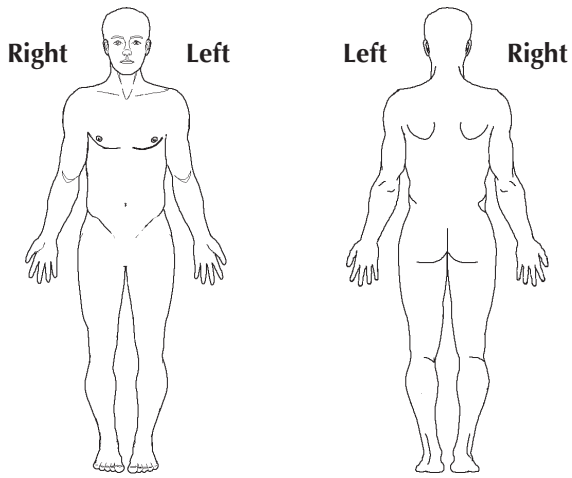
Date_____/_____/_____ Time:_____

Name:_____ _____ _____
Last First Middle Initial

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

1. Yes 2. No

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



3) Please rate your pain by circling the one number that best describes your pain at its WORST in the last 24 hours.

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 circling the one number that best describes your pain at its LEAST in the last 24 hours.

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 circling the one number that best describes your pain on the 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 circling 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 imagine

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

_____

_____

8) In the last 24 hours, how much relief have pain treatments or medications provided? Please circle the one percentage that shows how much RELIEF you have received.

0%	10	20	30	40	50	60	70	80	90	100%
No relief										Complete relief

9) Circle the one number that describes how, during the past 24 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

C. Walking ability

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

Opioid Risk Tool

This tool should be administered to patients upon an initial visit prior to beginning opioid therapy for pain management. A score of 3 or lower indicates low risk for future opioid abuse, a score of 4 to 7 indicates moderate risk for opioid abuse, and a score of 8 or higher indicates a high risk for opioid abuse.

Mark each box that applies	Female	Male
Family history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
Age between 16—45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
Scoring totals		

Questionnaire developed by Lynn R. Webster, MD to asses risk of opioid addiction.

Webster LR, Webster R. Predicting aberrant behaviors in Opioid-treated patients: preliminary validation of the Opioid risk too. Pain Med. 2005; 6 (6) : 432