MEDICAL HISTORY AND CURRENT MEDICAL CONDITION

FOR USE IN ASSESSMENT OF PATIENT'S MEDICAL HISTORY AND CURRENT MEDICAL CONDITION

Name: _____ Age: ____ Date of Birth _____Sex _____

Address: _____ City: _____ State: _____ Zip: _____

Cell phone #: _____Email:_____

Are you a Military Veteran? YES ___ NO ____

Family Doctor: _____ Doctor's Phone: _____

☒Check box if you want to be texted for follow up visits or recertification {carrier_____}

Do you want us to notify your primary care physician Yes____ No____
Do you need a caregiver? Yes___ No___ Do you want to be a caregiver? Yes___ No___

List Medicines: _____

List Allergies: _____

List Surgeries/Procedures and their approximate date/year:

_____

When was your last physical _____

What is your medical condition? _____

CURRENT MEDICAL CONDITION

Please Circle Appropriate Response:

NO YES Do you have any major health complaints at this time? _____
NO YES Are you disabled due to your medical conditions or treatments at this time?
NO YES Are you experiencing side effects as a result of drugs, medications, or treatment?
NO YES Are you experiencing severe and chronic pain as a result of your condition?
NO YES Are you experiencing nausea as a result of your condition?
NO YES Are you experiencing severe and persistent muscle spasms as a result of your condition?
NO YES Are you experiencing seizures?
NO YES Has the severe pain you are experiencing lasted longer than three months?
NO YES Has the nausea you are experiencing lasted longer than three months?
NO YES Has the severe & chronic muscle spasms you experience lasted longer than 90 days?
NO YES Are you experiencing loss of appetite as a result of treatment?

NO YES Are you in an Alcohol or Drug Treatment program?
NO YES Do you take any vitamins or homeopathic remedies/treatments?

NO YES Do you have Cancer?
NO YES Do you have Glaucoma?
NO YES Do you have Alzheimer's disease?
NO YES Do you have Positive Status HIV?
NO YES Do you have AIDS or an AIDS defining illness?
NO YES Do you have Hepatitis C?
NO YES Do you have Amyotrophic lateral sclerosis? (ALS - Lou Gehrig's Disease)
NO YES Do you have Crohn's disease?
NO YES Do you have Nail patella?
NO YES Do you have Epilepsy?
NO YES Do you have Multiple Sclerosis?
NO YES Do you have Diabetes?
NO YES Do you have Tourette's Syndrome?
NO YES Do you have Heart Disease?
NO YES Do you have Kidney Disease?
NO YES Do you have Fibromyalgia?
NO YES Do you have GI Disorders?
NO YES Do you have Gliomas?
NO YES Do you have Hypertension?
NO YES Do you have Anorexia?
NO YES Do you have Anxiety Attacks?
NO YES Do you have Arthritis?
NO YES Do you have Asthma?
NO YES Do you have Constipation?
NO YES Do you have Insomnia?
NO YES Do you have Intestinal Cramps?
NO YES Do you have Intractable Hiccups?
NO YES Do you have Meniere's Syndrome?
NO YES Do you have Migraine Headaches?
NO YES Do you have Neuralgia?
NO YES Do you have Neurodermitis?
NO YES Do you have Night Sweats?
NO YES Do you have Overly Painful Premenstrual Syndrome?
NO YES Do you have Respiratory Diseases?
NO YES Do you require Stress Reduction?
NO YES Do you ever suffered a Stroke?

NO YES Do you experiencing any other side effects besides severe and chronic pain, nausea, or severe and persistent muscle spasms as a result of treatment?

HIPAA Compliant Authorization:

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I hereby authorize you to release and discuss any and all medical health treatment records and information that you have in your possession regarding my health condition, including but not limited to my health history, my health treatment, your findings regarding my health, records of consultations that I have had, records of medication prescribed for me, X-rays taken of me, to the physicians, hospitals, and other facility treating me for the purpose of providing medical advice and treatment. I understand a covered entity may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization when the prohibition on conditioning of authorizations in 45 CFR164.508 (b)(4) applies. I am providing this authorization voluntarily and have not been required to give it to obtain treatment. I understand that I may revoke this Authorization at any time except to the extent that action has already been taken in reliance upon it before it is delivered. If I do not revoke it, this Authorization will expire one year after the date on which I signed it. I understand that information disclosed through this Authorization may be subject to re-disclosure and no longer protected by the privacy protections associated with HIPAA and 45 CFR 164.508. This document shall be governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub L No 104-191, and MCL 333.26261 et seq. However, I intend it to be honored in any jurisdiction where it is presented and for other jurisdictions to refer to Michigan law and HIPAA to interpret and determine the validity and enforceability of this document. Photocopies or facsimile reproductions of this signed authorization shall be treated as original counterparts. I authorize you to discuss my protected health information with anyone whose name or relationship I write below:

Patient Signature: _____ Date: _____

Physician Review

Ht _____ Wt _____ BP _____ AR _____

Comments/Conclusions:

_____

_____

Physician signature: _____Date:_____

PHYSICIAN'S STATEMENT

Certification of Medical Need for use of Marijuana

I certify that: _____ was evaluated by me, _____, for one or more medical conditions in reference to his /her need for medicinal marijuana(cannabis) qualifying with valid diagnoses for use under Michigan law. The patients' medical record and history were reviewed. Objective test results from medical testing facilities and specialists were reviewed. It is my professional medical opinion that the above named patient may benefit from the use of medical marijuana. I approve his/her use of marijuana for medicinal purposes as defined by State of Michigan law. I will continue to monitor his/her medical condition/s and to provide advice on his/her progress at least annually. I have discussed the potential risks and contraindications of marijuana (cannabis) with the patient. I have informed my patient not to use marijuana with alcohol and certain medications. I have ordered this patient not to drive motor vehicles, operate watercraft, aircraft, heavy machinery or engage in any activity that requires alertness while using medical marijuana. I have advised this patient of the MMMP law requirements for re-evaluations.

This is a medical certification of need for medical marijuana and is not a formal prescription for marijuana. It is a statement of my professional medical opinion. This opinion is rendered as a consultant with expertise in General Medicine and not in the capacity of his/her primary care provider. I repeat that this recommendation is in no way to be interpreted as a prescription as defined under Federal Law. It is a recommendation that adopts the legal provisions of Michigan Health and Safety Code and is only meant to be used or applied under Michigan Law. Under Federal Law cannabis is a scheduled drug and under Federal Law the sale, possession and cultivation of marijuana is illegal.

I have read and understand the above physician's statement. I have been informed of the privacy laws (HIPPA) and of the penalties under Michigan law for misrepresentation or fraudulence in presenting myself and my medical record for the examining physician. I have been advised on the safe and prudent use of medicinal marijuana (cannabis). I understand that it is my responsibility to insure that medical records supporting my use of medical marijuana have been reviewed by _____ and are on file at his office. I further understand that it is my responsibility to comply with the doctor's orders for periodic re-evaluations as required by State law.

IT IS THE PATIENTS RESPONSIBILITY TO DISCLOSE ANY EXISTING LEGAL MATTERS AND/OR SITUATION TO THE CERTIFYING PHYSICIAN THAT COULD AFFECT THE CERTIFICATION PROCESS, INCLUDING BUT NOT LIMITED TO PROBATION, RECENT ARRESTS, COURT APPEARANCES, DISCIPLINARY ACTIONS, UNPAID TRAFFIC FINES, ETC.

Patient Signature: _____ Date: _____

The Michigan Medical Marihuana Act
Bona Fide Physician-Patient Relationship a note about Follow-Up Care

Registering as a qualified patient under the Michigan Medical Marihuana Act (MMMA) requires a bona fide physician-patient relationship, as defined in the Act by P.A. 512 of 2012, the December 2012 legislative amendments to the Act which became effective April 1, 2013.

"Bona fide physician-patient relationship" means a treatment or counseling relationship between a physician and patient in which all of the following are present:

(1) The physician has reviewed the patient's relevant medical records and completed a full assessment of the patient's medical history and current medical condition, including a relevant, in-person, medical evaluation of the patient.
(2) The physician has created and maintained records of the patient's condition in accord with medically accepted standards.
(3) The physician has a reasonable expectation that he or she will provide follow-up care to the patient to monitor the efficacy of the use of medical marihuana as a treatment of the patient's debilitating medical condition.
(4) If the patient has given permission, the physician has notified the patient's primary care physician of the patient's debilitating medical condition and certification for the use of medical marihuana to treat that condition.

These criteria are used both by physicians in the practice of recommending medical marihuana to qualifying patients, and in the interpretation of eligibility for the legal protections of the Act by judges, prosecutors, and ultimately jurors, when determining if the patient or caregiver being prosecuted is qualified to use the Affirmative Defense. In most cases that lead to patient or caregiver arrest, the Affirmative Defense is the only way to force the courts to reach a reasonable decision. The purpose of this information is to make it clear to patients that the standard of care for certifying physicians has changed substantially. Please note the two major changes that have taken place with the amendments to the MMMA as of April 2013.

The first is that patient cards are now valid for 2 years. The second is that the act now defines what a bona fide physician-patient relationship means

YOUR NEXT FOLLOW-UP APPT IS: _____ Follow-up fee is $100

COMMON QUESTIONS

1.HOW DO I GO ABOUT BECOMING A MEDICAL MARIJUANA PATIENT IN MICHIGAN?
Approved by voters in November 2008, the act authorizes the use of marijuana to relieve certain qualifying medical concerns or conditions: cancer, glaucoma, HIV / AIDS positive, severe and/or chronic pain, severe nausea, seizures, including those that are characteristics of epilepsy; or persistent muscle spasms, including those that are characteristics of multiple sclerosis. Assuming you suffer from chronic pain or other symptoms above, a certified M. D. or D.O., can determine and if you so, certify you for the use of medical marijuana and fill out the proper documentation to send to The State of Michigan. Our office will help you fill out ALL the paperwork and will make sure that everything is filled out correctly and ready to send!

2.WHAT DOES IT CURRENTLY COST TO RECEIVE YOUR CERTIFICATION AND APPLY TO THE STATE?

Our doctor will certify you for a nominal fee. If you do not meet the certifying requirements you will not have to pay the fee. This certification process is not able to be covered by insurance, according the State of Michigan law, no government, private, or any other health insurance provider shall be liable for any claim for reimbursement for the medical use of marijuana. This also does not include the additional fee to the state. This fee is $ 60.00. There is an additional fee of $25 if you are going to have a caregiver.

3. HOW MUCH MEDICINE AM I LEGALLY ALLOWED TO POSSESS OR GROW?

A person who has been accepted as medical marijuana patient can possess up to two and a half (2.5) ounces of usable marijuana (seeds and stems do not apply to this weight) and grow up to twelve (12) plants for your use. You may transport up to 2.5 ounces at any given time in a closed container in the trunk of your motor vehicle.

4. HOW IS MY CONFIDENTIALITY PROTECTED?

Your confidentiality is protected by law and by the procedures used by the registry. No lists of doctors, patients of caregivers are given out to anyone. Local law enforcement may only contact the registry to verify the information on a specific identification card.

5. DO I HAVE TO GROW MY OWN MEDICINE? CAN SOMEONE ELSE GROW FOR ME? WHERE ELSE CAN I OBTAIN MY MEDICINE?

No, you do not have to grow your own medicine. Yes, you may give up your right to grow your own medicine to another person who is over the age of 21, and is not convicted of any felony involving drugs or any assaultive crimes, or any felonies committed within the past ten years of applying for a caregiver's license. This person would be called your "Primary Caregiver". You may also obtain your medicine from any Healthcare Collective in Michigan.

6. WHY CAN'T I GO TO A PHARMACY FOR A PRESCRIPTION FOR MEDICAL MARIJUANA?

Pharmacies can only dispense medications that are prescribed. Marijuana is currently classified by the federal government as a Schedule 1 drug, which means it cannot be prescribed by any health care professional. You can medicate yourself in the privacy of your own home, your relatives, and/or your friends as long as the owner and people present are ok with it. DO NOT share your medication with non-patients.

If you decide to register with the State of Michigan:

21 days after your check/money order is cashed by the state of Michigan and you have sent your application and all other necessary documentation, and you DID NOT receive anything from Lansing VIA Mail, CALL LANSING. You may go ahead and visit a compassion club WITH A COPY OF THE CASHED CHECK AND APPLICATION. Please check with your local club for information on their policies.