Green Medical and Consulting, LLC

Please fill out the information below to the best of your knowledge. If the question does not apply to you, please leave blank.

First name:_____Last name:_____

Address:_____

Tel: h_____w_____mobile_____

Gender: M F (please circle) Date of birth: _____

Social Security Number:_____

MEDICAL HISTORY

Past medical history (Such as diabetes, high blood pressure, back pain, etc…):_____

_____

Current Prescription and Over the Counter Medications:_____

_____

_

_____

_

Medication Allergies:_____

Tobacco use and frequency: _____

Alcohol use and frequency: _____

Illicit drug use and frequency: _____

PATIENT SIGNATURE: _____ DATE _____

Green Medical and Consulting, LLC

TREATMENT EFFECTIVENESS FOR QUALIFYING CONDITION
Please answer the following questions on how effective your current treatment plan is for your medical condition. **Current treatments (medications, therapy, etc…) for your medical condition**:_____ _____ _ _____ _ **How effective are these in your treatment? NOT AT ALL MILD MODERATE SIGNIFICANT** **<u>For individuals renewing their medical cannabis card:</u>** **How effective is medical cannabis in your treatment? NOT AT ALL MILD MODERATE SIGNIFICANT** **Are you having any side effects from medical cannabis? _____**

I certify the above information is true and correct :

PATIENT SIGNATURE: _____ DATE _____

Green Medical and Consulting, LLC

INFORMED CONSENT AND RELEASE FROM LIABILITY

I am being evaluated for a medical provider's qualification for admission into the Mississippi Medical Cannabis Program. The medical provider will make this qualification based, in part, on the medical information I have provided. I have not misrepresented my medical condition in order to obtain a qualification and it is my intent to use marijuana/cannabis only as needed for the treatment of my medical condition, not for recreational or non-medical purposes. I understand that it is my responsibility to be informed regarding state and federal laws regarding the possession, use sale/purchase and/or distribution of marijuana/cannabis.

I have been informed of and understand the following: [Initial each item]

____ Marijuana/Cannabis has not been approved by the FDA for marketing as a drug. Therefore the "manufacture" of marijuana/cannabis for medical use is not subject to any standards, quality control, or other oversight. Marijuana/cannabis may contain unknown quantities of active ingredients, impurities, contaminants, and substances in addition to THC, which is the primary psychoactive chemical component of marijuana/cannabis.

____ The use of marijuana/cannabis can affect coordination, motor skills, and cognition, such as the ability to think, judge, and reason. While using marijuana/cannabis, I should not drive, operate heavy machinery or engage in any activities that require me to be alert and/or respond quickly. I understand that if I drive while under the influence of marijuana/cannabis, I can be arrested for "driving under the influence."

____ Potential **SIDE EFFECTS** from the use of marijuana/cannabis include, but are not limited to, the following: Dizziness, anxiety, confusion, cough, bronchitis, lung problems, sedation, low blood pressure, impairment of short term memory, euphoria, nausea and vomiting (hyperemesis syndrome), difficulty in completing complex tasks, suppression of the body's immune system, inability to concentrate, impaired motor skills, paranoia, psychotic symptoms, general apathy, depression and or/restlessness. Marijuana/cannabis may exacerbate schizophrenia. In addition, the use of marijuana/cannabis may increase eating, alter my perception of time and space and impair my judgement.

____ I understand that using marijuana/cannabis while under the influence of alcohol, opioids/opiates, sedatives, or illicit drugs is not recommended. Additional side effects may become present when using both alcohol, opioids/opiates, sedatives, and illicit drugs with marijuana.

____ I agree to contact a medical provider or the emergency department if I experience any of the side effects listed above, or if I become depressed or psychotic, have suicidal thoughts, or

experience crying spells. I will also contact a medical provider or the emergency department if I experience respiratory problems, changes in my normal sleeping patterns, extreme fatigue, increased irritability, or begin to withdraw from my family and/or friends.
____ The risks, benefits and drug interactions of marijuana/cannabis are not fully understood. If I am taking medication or undergoing treatment for any medical condition, I understand that I should consult with my primary medical or mental health provider before using marijuana/cannabis and that I should not discontinue any medication or treatment previously prescribed unless advised to do so by the treating medical provider.

____ Individuals may develop a tolerance to, and/or dependence on, marijuana/cannabis. I understand that if I require increasingly higher doses to achieve the same benefit I could be developing a dependency on marijuana/cannabis and should seek medical assistance.

____ Signs of withdrawal can include: feelings of depression, sadness, irritability, insomnia, restlessness, agitation, loss of appetite, trouble concentrating, sleep disturbances and unusual tiredness.

____ Symptoms of marijuana/cannabis overdose include, but are not limited to, nausea, vomiting, hacking cough, disturbances in heart rhythms, numbness in hands, feet, arms or legs, anxiety attacks and incapacitation. If I experience these symptoms, I agree to go to the nearest emergency room.

____ If Green Medical and Consulting subsequently learns that the information I have furnished is false or misleading, the qualification for marijuana may no longer be valid. I agree to promptly meet with Green Medical and Consulting and/or provide additional information in the event of any inaccuracies or misstatements in the information I have provided.

____I have had the opportunity to discuss these matters with the medical provider and to ask questions regarding anything I may not understand or that I believe needed to be clarified.

I acknowledge that the Green Medical and Consulting provider informed me of the nature of the treatment of my medical condition, including but not limited to, voluntary treatment using medical marijuana/cannabis. The provider also informed me of the risks, complications, expected benefits of medical cannabis, including its likelihood of success and failure. I acknowledge the medical provider informed me of any alternative treatment options including the alternative of no treatment, and the risks and benefits.

Furthermore, I, the undersigned (including my heirs, or anyone acting on my behalf), hold Green Medical and Consulting LLC, the medical provider and his/her principals, agents, employees and management, harmless and release them from any liability resulting in any way whatsoever

from my use of marijuana/cannabis. This release of liability includes, but is not limited to, any bodily or psychological injury, whether known or unknown, as well as legal and/or employment problems resulting from my use of marijuana/cannabis.

_____

Patient Signature DATE

_____

Printed Name.

Green Medical and Consulting LLC

I understand that the information I have been asked to provide is for the evaluation of my medical condition and to determine if it is a qualifying medical condition approved under the Mississippi Medical Cannabis Program, and if I have not accurately and completely disclosed the requested information, it may adversely impact the provider's ability to diagnose my condition and/or determine whether I qualify for medical cannabis per Mississippi state law.

I certify: [initial each item]
____I certify that the information I am providing is accurate and complete and has been offered only for the purpose of determining if I have a qualifying medical condition.
____I certify that my condition is chronic and debilitating to my quality of life.
____I certify that I am not seeking marijuana for illegal purposes.

I understand: [initial each item]
____ The medical provider, staff and representatives of Green Medical are addressing specific questions regarding my qualification for entry into the Mississippi Medical Cannabis program, and unless otherwise stated, are in no way establishing themselves as my medical provider beyond the requested evaluation/consultation. All patients should follow up with their primary care provider or mental health provider as appropriate.

____ Should an approval be made for my medicinal use of cannabis, there is a renewal date specified by the state. It is my responsibility to see the medical provider to assess the possible continuance of cannabis use beyond the term of approval.

____ I acknowledge that I am a resident of Mississippi, I am at least 18 years of age and have not misrepresented any information to Green Medical

____ I acknowledge that I have voluntarily sought an evaluation from Green Medical and am in no way being coerced to do so.

____ I acknowledge that evaluation does not ensure a medical cannabis card and if a denial is issued, I am not entitled to a refund.

____ I acknowledge the federal government has classified marijuana as a Schedule 1 controlled substance. Schedule 1 substances are defined, in part, as having 1. a high potential for abuse; 2. no currently accepted medical use in treatment in the United States; and 3. a lack of accepted safety for use under medical supervision. Federal law prohibits the manufacture, distribution, and possession of marijuana even in states, such as Mississippi, which have modified their state laws to treat marijuana as a medicine.

_____

Patient Signature DATE