



MEDICAL MARIJUANA

“New to Us” Patient Instructions: Please fill out all pages of these forms. Page 8 should be completed only if you need to request copies of your medical records. These forms may be filled out in 2 ways:

1. Use the Typewriter Tool in Adobe Acrobat Reader to fill them out, then PRINT the completed forms and sign where required.
2. You may also just print the forms, fill them out by hand, and sign where required.

PLEASE BE SURE TO BRING THE COMPLETED FORMS WITH YOU TO YOUR APPOINTMENT!

First Name:	MI:	Last Name:	
CA Drivers License:	State ID Card:		
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:		Rev. 2011-06-24
Phone:	Email:		
Street Address1:			
Street Address2:			
City:	State: <input type="checkbox"/> CA	Zip:	

RENEWAL REMINDER? May we send a reminder that your recommendation for medical marijuana is about to expire, to the email address listed above, 30 days before your recommendation is due to expire?

- Yes, please send an email reminder.
 No, do not send an email reminder.

PATIENT SIGNATURE

DATE

MEDICAL MARIJUANA NEW PATIENT PROBLEM HISTORY

LAST NAME:	FIRST NAME:	MI:
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1. Please list the Condition(s) for which you seek relief with Medical Marijuana AND the YEAR that condition began in the boxes below:

2. **CIRCLE** any of the conditions you listed above for which you have you seen an Approved Health Care Provider (see list below).

3. Are you currently being treated for your condition(s) by one of the "**Approved Health Care Providers**" listed below? Yes No

4. When was the last time you saw one of the "**Approved Health Care Providers**" listed below for your condition?

<input type="checkbox"/> 1 month ago or less	<input type="checkbox"/> 3 months ago or less	<input type="checkbox"/> 6 months ago or less	<input type="checkbox"/> 1 yr ago or less
<input type="checkbox"/> 1-3 years ago	<input type="checkbox"/> 3-7 years ago	<input type="checkbox"/> more than 7 years ago	<input type="checkbox"/> Never

5. Do you have medical records with you that support your condition? Yes No

6. Can you get medical records* that support your condition? Yes No
 *Medical records are generally kept for 7 yrs by doctors and hospitals.

7. Please list any medicines that have been prescribed for your condition(s) and any adverse reactions you may have had to those medicines in the table below. You may continue at the bottom of the page:

Medicine	Adverse Reaction	Did the medicine help?
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Somewhat
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Somewhat
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Somewhat

8. Check any treatments, other than medications, you may have had for this condition and whether of not it helped.

Treatment	Did it help?	Treatment	Did it help?
<input type="checkbox"/> Acupuncture	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Somewhat	<input type="checkbox"/> Psychotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Somewhat
<input type="checkbox"/> Chiropractic care	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Somewhat	<input type="checkbox"/> Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Somewhat
<input type="checkbox"/> Physical therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Somewhat	<input type="checkbox"/> Chinese herbs	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Somewhat

9. List any other treatment(s) you may have had?

10. Did it help? Yes No Somewhat

11. Have had surgery for this condition. Yes No If yes, how many times?

12. Have you used cannabis for this condition? Yes No

13. Did it help? Yes No Somewhat

Additional Information:

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Approved Health Care Providers

Physicians (M.D. or D.O.) Licensed Acupuncturist (L.Ac.) Doctor of Chiropractics (D.C.) Doctor of Naturopathy (N.D.) Dentist (D.D.S. or D.M.D.) Licensed Marriage and Family Therapist (LMFT)	Podiatrist (D.P.M.) Psychiatrist (M.D.) Psychologist (Psy.D. or Ph.D.) Licensed Clinical Social Worker (LCSW) Optometrist (O.D.) Other qualified, licensed professional:
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Last Name:	First Name:	Middle Initial:
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Cannabis Use Questions

1. How effective has medical marijuana been in treating your condition(s)?
 - Very effective
 - Somewhat effective
 - Not at all effective
2. Have you discontinued medical marijuana and found that your condition worsened?
 - Yes
 - No
3. Have you stopped using medical marijuana because of bothersome side effects?
 - Yes
 - No
4. Did the use of medical marijuana modify your use of prescription or over-the-counter (OTC) drugs?
 - I was able to stop all my prescription and/or OTC drugs
 - I was able to reduce my prescription and/or OTC drugs
 - I found that medical marijuana and my prescription/OTC drugs work best together
 - Prescription drugs are useless for my condition
5. How often do you use medical marijuana?
 - Less than once a month 1-3 times per month Once a week
 - 2-4 times a week Almost daily Once a day
 - Twice a day Three times a day or more
6. If you are a daily user, what is the average amount of medical marijuana you use per day? (A large joint is about 1 gram, 1/8 oz = 3.5 grams)
 - less than 1 gram 1 gram 2 grams 3 grams More than 3 grams
 - I am not a daily user so this does not apply to me
7. Has the amount of medical marijuana needed to control your symptoms increased, decreased, or remained the same over time?
 - Increased; it now requires more medical marijuana to control my symptoms
 - Decreased; it now requires less medical marijuana to control my symptoms
 - Remained about the same
8. Are you experiencing any problems with the treatment plan provided at the time of your last visit?
 - Yes
 - No
9. Do you have any questions or concerns about medical marijuana you would like the doctor to address today?
 - Yes
 - No
10. How do you medicate with medical marijuana? Please check all that apply.
 - smoke ☹️ vaporize 😊 eat or ingest 😊
 - apply cream, lotion, or ointment containing medical marijuana topically to skin
11. Do you smoke tobacco products
 - Yes, I smoke tobacco. ☹️
 - No, I do not smoke tobacco. 😊
12. Do you primarily grow or purchase your medical marijuana?
 - I primarily grow my own medical marijuana.
 - I primarily purchase medical marijuana.
13. If you grow medical marijuana, are you able to grow enough to meet your personal medical marijuana needs using the county garden guideline of 12 plants total, of which 6 may be mature budding females?
 - Yes, and I have not had to purchase any additional medical marijuana from dispensaries or collectives.
 - No, I must still purchase medical marijuana from dispensaries/collectives.

Sign your name above

Date

ACKNOWLEDGMENT AND CONSENT
MMOC / MMSD

Initials

- _____ I voluntarily consent to receive medical and health care services from Bob E. Blake, M.D., A Professional Corporation (APC) and its physicians.
- _____ I have been assured that records relating to my care will be kept confidential and that no information will be released or printed that would disclose personal identity, unless required by law.
- _____ I authorize Bob E. Blake, M.D., APC to verify that I have received a recommendation to use medical marijuana to Law Enforcement officials, dispensaries, collectives and coops.
- _____ I understand that I must be a California State resident to obtain a physician's recommendation for the use of medical marijuana. Non-California residents are not able to use medical marijuana while in California under California's Compassionate Use Act of 1996 (Health & Safety Code #11362.5).
- _____ I am aware that a Notice of Compliance has not been issued by the Food and Drug Administration concerning the safety and effectiveness of marijuana as a drug and I understand the significance of this fact.
- _____ I consent to using marijuana only for the treatment of the symptoms stated in the medical declaration.
- _____ I am aware that medical marijuana has not been approved under Federal Regulations and I understand that medical marijuana has not been deemed legal under federal law.
- _____ I understand the potential risks associated with use medical marijuana, including risks with respect to the effects upon my cardiovascular and pulmonary systems (heart and lungs) and psychomotor performance, risks associated with the long-term use of marijuana, as well as potential drug dependency.
- _____ I am aware that the benefits and risks associated with the use of marijuana are not fully understood and that the use of marijuana may involve risks that have not been identified; I accept those risks.
- _____ I accept all the aforementioned risks and will not hold Bob E. Blake, M.D., APC or any of its physicians responsible for any medical or legal ramifications.
- _____ I understand that I am not to drive, operate machinery, or engage in hazardous activities, while under the influence of medical marijuana.
- _____ Furthermore, I, the undersigned, my heirs, assignees, or anyone acting on my behalf, hold Bob E. Blake, M.D., APC and its physicians, principals, agents, and employees, free of and harmless from any liability resulting from my use of cannabis.
- _____ I attest that the information I have submitted to Bob E, Blake, M.D. APC, is correct and any medical history presented to the doctor is also factual and complete to the best of my knowledge. I do not plan or intend to use my Physician's recommendation for the purpose of illegally obtaining or illegally distributing medical marijuana.
- _____ I affirm that I am a California state resident and that I have a serious medical condition that adversely affects my quality of life. I have found, or am interested in finding whether medical marijuana provides substantial relief and improvement in my condition.
- _____ I acknowledge that I am not an agent of law enforcement, state or federal government here for the purpose of investigation or entrapment.
- _____ I acknowledge that I am not recording any portion of my visit with Bob E. Blake, M.D., APC and its physicians and staff, nor do I possess any audio or video recording equipment. I understand Bob E. Blake, M.D., APC does not approve such action.

PRINT YOUR NAME ABOVE

X_____

PATIENT SIGNATURE

DATE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
AT THE OFFICE OF BOB E. BLAKE, M.D., A PROFESSIONAL CORPORATION

How would you like to be contacted for matters such as appointment reminders and other Protected Health Information? Please check all that apply:

HOME TELEPHONE - IT IS OK TO CALL MY HOME PHONE.

Phone number: (____) _____ - _____

It is Ok to leave message to call back the office of Dr. Bob Blake on my home phone.

It is OK to leave message with detailed information on my home phone.

CELL TELEPHONE - IT IS OK TO CALL MY CELL PHONE.

Phone number: (____) _____ - _____

It is Ok to leave message to call back the office of Dr. Bob Blake on my cell phone.

It is OK to leave message with detailed information on my cell phone.

WORK TELEPHONE - IT IS OK TO CALL MY WORK PHONE.

Phone number: (____) _____ - _____

It is Ok to leave message to call back the office of Dr. Bob Blake on my work phone.

It is OK to leave message with detailed information on my work phone.

MAIL (USPS)

Okay to send mail to my **home** address

Street Address: _____ Apt _____

City: _____ State _____ Zip _____

Okay to send mail to my **work** address. If Yes;

Send to: _____

Street Address: _____ Apt _____

City: _____ State _____ Zip _____

Ok to send **email** to the following email address: _____@_____

Ok to send fax to the following Fax number: (____) _____ - _____

The HIPAA privacy rule gives individuals the right to determine how their Protected Health Information (PHI) is used and to whom it may be disclosed. It is our policy not to disclose any of your PHI to anyone unless we are specifically authorized to do so by you, in writing, with a signed Medical Information Release. We will notify you if we receive a subpoena for any of your PHI. You may then decide whether or not you want to authorize us to release any of your PHI. Without your authorization it will take a Judge's Subpoena or Court Order for us to release any of your PHI. It is essential that we have a way to contact you.

The individual is also provided the right to request confidential communications and communication of PHI be made by alternative means such as sending correspondence to the individuals office instead of the individuals home. The Privacy Rule generally requires health care providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose.

I hereby acknowledge that I have read the Notice of Privacy Practices ('Notice') was given to me upon arrival at Dr. Bob Blake's office.

Print Name _____ Date _____

PATIENT SIGNATURE

POSSIBLE SIDE EFFECTS OF MEDICAL MARIJUANA
MMOC / MMSD

“MEDICAL MARIJUANA” (MEDICINAL CANNABIS, CANNABIS, TETRAHYDROCANNABINOLS)

CONTRAINDICATIONS:

Hypersensitivity to tetrahydrocannabinol (THC) or dronabinol (synthetic THC).

PRECAUTIONS:

Cardiac disorders such as arrhythmias, cardiac ischemia (usually manifest as either angina or a heart attack), concomitant **use of sedatives or other psychoactive drugs**, **elderly patients** may be more sensitive to psychoactive effects, **history of substance abuse**, history of **psychiatric illness**.

Do not drive, operate machinery, or engage in hazardous activities.

Do not use during pregnancy or lactation.

COMMON ADVERSE EFFECTS

Abnormal thinking, impaired perception, impaired judgment, loss of motivation, diminished short-term memory, loss of concentration, depersonalization, euphoria, anxiety, panic attacks, paranoia, confusion, hallucinations, depression, dizziness/vertigo, drowsiness, diminished inhibitions; impaired coordination, increased risk of accidents, dry mouth, nausea, vomiting, high or low blood pressure, irregular heartbeat, increased heart rate, and “red” flushing of skin

DRUG INTERACTIONS

Ritonavir (an antiviral agent used to treat patients who are HIV positive or have AIDS)

PREGNANCY: CATEGORY C

Animal reproduction studies have shown an adverse effect on the fetus and there are no adequate and well-controlled studies in humans, but potential benefits may warrant use of the drug in pregnant women despite potential risks. Most prescription medications are classified in Category C.

BREAST FEEDING

Potential risk; change in therapy or care plan may be advisable.

The doctor has provided and/or discussed the side effects of Medical Marijuana, and has offered a more comprehensive copy of the side effects of the medicinal use of cannabis.

X _____

PATIENT SIGNATURE

_____ DATE

MEDICAL RECORDS POLICY OF BOB E. BLAKE, M.D., APC

Q. WHY ARE WE REQUESTING YOUR MEDICAL RECORDS?

A. Because it is required that we do so by the California Medical Board! For your protection we strictly adhere to ALL rules and regulations set forth by the California Medical Board (CMB). We suggest that you visit the following web site for the complete text of the CMB's position statement on Medical Marijuana.

http://www.medbd.ca.gov/medical_marijuana.html

We have quoted the pertinent section of this document immediately below:

5. A physician who is not the primary treating physician may still recommend medical marijuana for a patient's symptoms. However, it is incumbent upon that physician to consult with the patient's primary treating physician or obtain the appropriate patient records to confirm the patient's underlying diagnosis and prior treatment history.

Our doctors act as Medical Marijuana Consultants only, NOT as your primary treating physician. Therefore, you are required to provide us with medical records that confirm your qualifying diagnosis, either at the time of your initial visit OR within the timeframe specified by the physician by whom you are seen at our clinic. Usually medical records will be due no later than 3 months after your initial visit.

The medical records that you submit should be from one of the Approved Licensed Health Care Providers listed below.

Approved Licensed Health Care Providers

Physicians (M.D. or D.O.)
Licensed Acupuncturist (L.Ac.)
Doctor of Chiropractics (D.C.)
Doctor of Naturopathy (N.D.)
Dentist (D.D.S. or D.M.D.)
Licensed Marriage and Family Therapist (LMFT)

Psychiatrist (M.D.)
Psychologist (Psy.D. or Ph.D.)
Licensed Clinical Social Worker (LCSW)
Optometrist (O.D.)
Other qualified, licensed professional you deem as your primary care provider.

Q. WHAT IF I HAVE NEVER SEEN A DOCTOR FOR MY CONDITION?

A. If you have never seen one of the providers listed above for your condition and upon examining you our doctor determines that you indeed suffer from a condition which would qualify you for a medical marijuana recommendation, you will be given a 3 month temporary recommendation and **REQUIRED** to see the provider of your choice from the list of approved licensed providers above, from whom we will then be able to obtain records in support of your qualifying condition. Upon receipt of your medical records your recommendation may then be extended to its full length, up a maximum of one year, depending upon your condition.

I have read the medical records policy above.

X _____
PATIENT SIGNATURE

DATE

REQUEST FOR RELEASE OF MEDICAL RECORDS

Patients Name: Last _____ First _____ Middle _____

DOB: _____ Previous Names Used: _____

Driver's License State ID Card _____ Passport# _____

X _____

PATIENT SIGNATURE

_____ DATE

By signing above, I Hereby Authorize (print name and address of your health care practitioner below):

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

Phone: _____ Fax: _____

TO RELEASE INFORMATION TO:

Bob E. Blake, M.D. , APC
28 Monarch Bay Plaza, Suite B
Dana Point, Ca 92629

FAX: 201-301-0104

I request that copies of my medical records including, but not limited to, the following items be sent:

Problem list/medication list (Summary only)

Mental health problem list/medication list (Summary only, do not include psychotherapy session notes)

History and Physical Examination

Hospital Discharge summary

Other _____

Note: We do not need your entire medical record; **a summary** of the Medical and/or Mental health Problem list and a Medication list will generally suffice.