STILL RIVER Wellness

PATIENT INTAKE FORM

Name: _____

Date of Birth: _____ / _____ / _____ Gender: ☐ Male ☐ Female

Address: _____

City / Town: _____ State: _____ Zip Code: _____

Phone Number: _____

Email: _____

Registered Caregiver (if applicable): _____

Eligible Discount Programs (if applicable)

- ☐ Compassionate Care Program (subject to application review)
- ☐ Veteran (with valid ID)
- ☐ Senior Citizen (65 +)
- ☐ Child (Under 18 years of age)

Brief Medical History

Tobacco Use: ☐ Yes ☐ No

Alcohol Use: ☐ Yes ☐ No

Allergies

☐ Coconut
☐ Gluten
☐ Other: _____
☐ Vegan

Health Conditions:

_____

_____

Current Medications:

_____

_____

MEDICAL CANNABIS ACKNOWLEDGMENT OF DISCLOSURE AND INFORMED CONSENT

There is limited information on the side effects of using cannabis, and there may be associated health risks. Side effects of cannabis can include, but are not limited to:

- Memory loss
- Dry Mouth
- Sexual Impotence
- Low blood pressure
- Confusion
- Anxiety / Nervousness
- Irregular / Increased Heartbeat
- Numbness
- Agitation
- Dizziness / Impairment of motor skills
- Dependency
- Impaired Vision
- Laryngitis / Bronchitis
- Headache / Nausea / Vomiting
- Paranoia / Psychotic Symptoms
- Hunger/Loss of appetite
- Cough/Bronchitis/Shortness of breath
- Poor physical condition
- Depression
- Feelings of euphoria
- Drowsiness/ Fatigue/Abnormal Sleep
- Sedation/slower reaction time/Inability to concentrate
- Suppression of immune system

Symptoms of cannabis overdose include, but are not limited to, nausea, vomiting, and disturbances to heart rhythm. This acknowledgment of disclosure is to advise you of risks and side effects of using cannabis medicines. It is important you review this document and discuss any questions you may have with the dispensary pharmacist.

Please do not sign this agreement if you do not understand the information you have received or not comfortable with the risks that may be related to cannabis use or possession.

Patient Signature: _____ **Date:** _____

MEDICAL CANNABIS PATIENT AGREEMENT

I agree that the following statements are true and accurate:

- I am over 18 years of age and I am registered with and understand the requirements of the State of Connecticut's medical marijuana program.
- I agree to strictly comply with the regulations, terms and conditions of the State of Connecticut's medical marijuana program. No cannabis obtained by me shall be used for any other purpose than as directed by my certifying physician. I understand cannabis is not to be resold, distributed, or used by any other person.
- I fully accept the responsibility in using cannabis and I certify I fully understand the potential risks related to the use of cannabis products.
- If I start using cannabis, I agree to tell my physician if I experience any one or more of the following:
    - Start to feel sad or have crying spells
    - Have changes in my normal sleep patterns
    - Loss of appetite
    - Become more irritable than usual
    - Become unusually tired
    - Withdraw from my family and/or friends
    - Lose interest in your usual activities

- If I experience a severe adverse reaction, I am advised to immediately contact my physician. If my physician is not available, I agree to call 911 for help, lie down and relax until help arrives.

- I agree to tell my physician if I have ever had symptoms of schizophrenia, bipolar disorder, psychotic episodes or attempted suicide. I also agree to tell my medical professional if I have ever been prescribed or taken medicine for any of these problems. I acknowledge that the risks of using cannabis under these circumstances could be severe.

- I understand that my physician does not suggest nor condone that I cease treatment of medications that stabilize my mental or physical condition.

- I am not pregnant, intending to become pregnant, or breastfeeding.

I certify that I have read this document and declare that the information contained herein is true, correct and complete.

Patient Signature: _____ Date: _____

Please be advised of the of the following:

- Possession or use of this product is unlawful outside of the State of Connecticut

_____
Initial Here

- Cannabis-based medicine may have intoxicating effects and has not been analyzed or approved by the united states Food and Drug Administration and was produced without FDA oversight for health, safety, or efficacy. Medical cannabis may contain unknown quantities of active ingredients, impurities or contaminants.

_____
Initial Here

- The efficacy and potency of cannabis may vary widely depending on the cannabis strain and ingestion method.

_____
Initial Here

- If the cannabis is smoked or vaporized: Smoking may be hazardous to your health. Cannabis smoke contains carcinogens and may lead to an increased risk of cancer, tachycardia, hypertension, heart attack, birth defects, brain damage, and lung disease.

_____
Initial Here

- If cannabis is eaten or swallowed: This product has been infused with cannabis or active compounds of cannabis. When eaten or swallowed, the intoxicating effects of this drug may be delayed by two or three hours or more.

_____
Initial Here

HEALTH INFORMATION PRIVACY POLICY AND PRACTICES

As a patient of Still River Wellness, I understand I have rights to privacy of my protected health information as defined by the Health Insurance Portability and Accountability Act of 1996.

I have been made aware that upon request a copy of Still River's Privacy Policy is available to me.

Still River Wellness has made me aware of their right to change the terms of its Notice of Privacy Practice.

Patient Signature: _____ Date: _____