

Southern Oregon Alternative Medicine INTAKE FORM

Please complete the information so we can better serve you.

Date: _____

Patient: _____
(Last) (First) (MI)

Mailing Address: _____

Physical Address: _____

City: _____ ZIP: _____ State: _____

Home Phone: _____ Cell Phone: _____

Work Phone : _____ ODL/ID# _____

Date of Birth: _____ Male/Female (please circle one)

Email Address: _____

Current Medications (all prescription, OTC's, herbals, vitamins, etc.): _____

Have you been seen here before: _____ Yes _____ No

Have you ever had an Oregon Medical Marijuana Card: _____ Yes _____ No

If yes, when did/do you expire? _____

Are you on probation or parole? _____ Yes _____ No

If yes, for what? _____

How did you hear about us? _____

Patient has read and completed Intake Form truthfully and understands that appointment cancellation needs to be 24 hours prior to appointment or fees will be charged.

Patient Signature: _____

Date: _____

Medical Cannabis Treatment Plan

Patient: _____

Date: ____/____/____

OMMP Application Review: Initial Lapsed Renewal

Patient medical history questionnaire and supporting documentation from previous/current medical specialist and primary care physician’s have been reviewed. Comprehensive physical examination completed.

The use of medical marijuana or cannabis, via inhalation and/or ingestion, is recommended as an adjunct to the patient’s current therapeutic regimen in an effort to reduce the debilitating effects of their chronic medical condition(s) and/or symptoms(s). ***This is not a prescription for medical marijuana.***

Patient is personally and wholly responsible for complying with all legal requirements involved with the participation in the Oregon Medical Marijuana Program and the laws of the State of Oregon. Patient shall make use of medical marijuana in order to relieve pain, improve function, increase ability to work, and reduce other symptoms. Medical marijuana is not for “feeling good” or “getting high.” Patient will not share or provide samples of their cannabis to anyone who is not a registered OMMP member.

Patient shall not partake of alcoholic beverages or sedating medication concurrently with medical marijuana use. The combined use of medical marijuana with narcotic analgesics may increase either drug’s effects and therefore needs to be monitored closely and may require dosage modifications. Patient shall not operate motor vehicles, machinery, or participate in their normal work activities if overly influenced by the effects of marijuana. Patient judgment is required and adverse events are subject to legal and financial repercussions that are the patient’s full responsibility, as the OMMA, via the legislative act, does not provide protection for or justification of such actions. Patient is to notify the office if they experience any adverse reactions or significant side effects with the use of medical cannabis.

Patient shall maintain an ongoing relationship and follow-up with their other health care providers in order to continue the current therapies prescribed and to determine if changes in therapy need to be considered.

The main goal of medical marijuana use is to improve the patient’s ability to function at home and/or work. A healthier lifestyle can help provide the most successful outcome to treatment and include such habits as exercise, weight loss, a balanced diet regimen, avoidance of all tobacco products, and no use of illicit drugs or non-prescribed or unapproved medications.

Patients agree to submit random urinalysis and/or blood testing, at their own expense, at the attending physician’s request. Refusal to submit to a requested test or testing positive for any illicit or non-prescribed medications will be grounds for dismissal from the clinic, revocation of their current OMMP card, and no further renewal applications will be accepted or approved.

Patient’s reported use of medical marijuana is: (check and circle ALL that apply)
Route: () **Inhaled**- smoked vaporized () **Ingested**- Butter Oil Tincture Capsules Raw () **Topical**

Average **FREQUENCY** of use per day (not amounts) _____

Patient Signature

Recommended Follow-Up Interval: 12 months

Jeanette C. Paysse M.D.

**ATTENDING PHYSICIAN'S STATEMENT
Oregon Medical Marijuana Program**

Instructions: Please complete all sections of this form in order to comply with the registration requirements of the Oregon Medical Marijuana Act OR provide relevant portions of the patient's medical record containing all information required on this form. **This does not constitute a prescription for marijuana.**

PLEASE TYPE OR PRINT LEGIBLY.

| | | |
|---|------------------------------|---|
| A | PATIENT INFORMATION | |
| PATIENT NAME (LAST, FIRST, M.I.) | | DATE OF BIRTH: |
| MAILING ADDRESS: | | TELEPHONE #: () |
| CITY, STATE AND ZIP CODE: | | |
| B | PHYSICIAN INFORMATION | |
| PHYSICIAN NAME: Dr. Jeanette C. Paysse, M.D. | | |
| MAILING ADDRESS: 836 E. MAIN ST. STE. 6 | | TELEPHONE #: (541) 779-5235 |
| CITY, STATE AND ZIP CODE: MEDFORD, OR 97504 | | |
| C | PHYSICIAN'S STATEMENT | |
| Debilitating Medical Condition: Check appropriate boxes. | | |
| <input type="checkbox"/> 1. Malignant neoplasm (Cancer) | | |
| <input type="checkbox"/> 2. Glaucoma | | |
| <input type="checkbox"/> 3. Positive status for Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) | | |
| <input type="checkbox"/> 4. Agitation due to Alzheimer's Disease | | |
| 5. A medical condition or treatment for a medical condition that produces for a specific patient one or more of the following: (check all that apply) | | |
| <input type="checkbox"/> a. Cachexia | | |
| <input type="checkbox"/> b. Severe pain | | |
| <input type="checkbox"/> c. Severe nausea | | |
| <input type="checkbox"/> d. Seizures, including but not limited to seizures caused by epilepsy | | |
| <input type="checkbox"/> e. Persistent muscle spasms, including but not limited to spasms caused by Multiple Sclerosis. | | |
| Comments: | | |
| I hereby certify that I am a physician duly licensed to practice medicine in Oregon under ORS Chapter 677. I have primary responsibility for the care and treatment of the above-named patient. The above-named patient has been diagnosed with a debilitating medical condition, as listed above. Marijuana used medically may mitigate the symptoms or effects of this patient's condition. | | |
| <u>This is not a prescription for the use of medical marijuana.</u> | | |
| PHYSICIAN'S SIGNATURE: | | DATE: |

MAIL ATTENDING PHYSICIAN'S STATEMENT TO:

DHS/OMMP
PO Box 14450
Portland, OR 97293-0450

Southern Oregon Alternative Medicine

Patient Assessment

Patient Name: _____ Date: _____

Answer the following questions based on what has happened in the last 6 months. Please number and explain
Each YES answers on the lines below.

- | | | | | |
|--|--|--------------------|--|----|
| 1. Have you had any changes in your medical condition or pain levels, Good or Bad? | | Yes | | No |
| 2. Do you have any new numbness, weakness, or other new problem? | | Yes | | No |
| 3. Any problems with nausea, vomiting, urination, or bowel movements? | | Yes | | No |
| 4. Have there been any changes in your sexual function? | | Currently Inactive | | No |
| 5. Have you had any blood work or special studies done recently? | | Yes | | No |
| 6. Are you doing any physical therapy or home exercise? | | Yes | | No |
| 7. Do you currently smoke cigarettes, chew tobacco, or drink alcohol? | | Yes | | No |
| 8. Have you experienced any side effects due to the use of cannabis? | | Yes | | No |
| 9. Are any of you other medications giving you side effects? | | Yes | | No |
| 10. Did you Stop your cannabis use and found a worsening or return of your symptoms: | | Yes | | No |
| 11. Has your cannabis use changed? (method of use, frequency, etc.) | | Yes | | No |
| 12. Have you experienced any issues at work or other places due to cannabis? | | Yes | | No |
| 13. Have you experienced any legal issues regarding the use of cannabis? | | Yes | | No |
| 14. Is cannabis effective in relieving you medical condition(s) and/or symptom(s)? | | Yes | | No |

Primary Care Physician: _____ Card Expires: _____

Using the Comparative Pain Scale, please circle the number that best describes you pain levels.

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|----|
| Your pain intensity at its Least ? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Your pain intensity at its WORST ? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Your pain Intensity at its AVERAGE ? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Your pain intensity RIGHT NOW ? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

Limited Physical Examination Performed: _____ Lungs: CTAB with good excursion _____ Heart: RRR with o MRG _____
Edema: _____

Jeanette C. Paysse M.D.