

# 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 need 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) \_\_\_\_\_

Recommended Follow-Up Interval: **12months**

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Dr. Wayde C. Perry MD**

## 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.**

If you need this document in an alternate format, please call (971) 673-1234

PLEASE TYPE OR PRINT LEGIBLY.

<b>A</b>	<b>PATIENT INFORMATION</b>	
PATIENT NAME (LAST, FIRST, M.I.)	DATE OF BIRTH:	
MAILING ADDRESS:	TELEPHONE #: (    )	
CITY, STATE AND ZIP CODE:		
<b>B</b>	<b>PHYSICIAN INFORMATION</b>	
PHYSICIAN NAME:	<b>Dr. Wade C. Perry</b>	
MAILING ADDRESS:	<b>152 Main Street</b>	TELEPHONE #: <b>( 541 ) 844-1708</b>
CITY, STATE AND ZIP CODE: <b>SPRINGFIELD, OR 97477</b>		
<b>C</b>	<b>PHYSICIAN'S STATEMENT</b>	
Debilitating Medical Condition: Check appropriate boxes.		
[ ] 1. Malignant neoplasm (Cancer)		
[ ] 2. Glaucoma		
[ ] 3. Positive status for Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)		
[ ] 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)		
[ ] a. Cachexia		
[ ] b. Severe pain		
[ ] c. Severe nausea		
[ ] d. Seizures, including but not limited to seizures caused by epilepsy		
[ ] 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 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.		
<b><u>This is not a prescription for the use of medical marijuana.</u></b>		
<b>PHYSICIAN'S SIGNATURE:</b>	<b>DATE:</b>	

MAIL ATTENDING PHYSICIAN'S STATEMENT TO:

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



# Southern Oregon Alternative Medicine

152 Main Street  
Springfield, Oregon 97477  
Ph: 541-844-1708 Fax: 541-515-6957

## Instructions for Patient:

If you need to cancel or reschedule your appointment, we require a *24-hour business day* notice by calling 541-779-5235 or a late cancellation fee will be charged to you. **Remember that all fees are due at the time of service. We don't accept personal checks.**

## Please Take Note of Doctor's Instructions:

- Call 541-779-5235 to schedule your Follow-Up appointment in \_\_\_\_\_ months or about \_\_\_\_\_.
  - You have been given a Follow-Up Warning. Failure to do your Follow-Ups with us may result in dismissal from this clinic.
- Get medical records from the following providers from the time periods indicated and submit them or bring to your next appointment.
  - Primary Care Physician \_\_\_\_\_
  - Specialist \_\_\_\_\_
  - Other \_\_\_\_\_
  - Hospital/Urgent Care \_\_\_\_\_
  - Specific Items \_\_\_\_\_
- Schedule Renewal appointment 2-3 months before your expiration date of \_\_\_\_/\_\_\_\_/\_\_\_\_.
- You have been advised to follow-up with \_\_\_\_\_  
for \_\_\_\_\_.
- It has been suggested for you to try the following: \_\_\_\_\_  
\_\_\_\_\_.

**You must have all forms completed before your appointment. You must have and/or ALL requested records that document your debilitating condition. If you don't bring sufficient or requested records you will be placed on hold and there will be a record review fee for reviewing records after your appointment time.**

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
De Wayde C. Perry, M.D.

# 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 | Yes | 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

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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 <b>Least</b> ?	0	1	2	3	4	5	6	7	8	9	10
Your pain intensity at its <b>WORST</b> ?	0	1	2	3	4	5	6	7	8	9	10
Your pain Intensity at its <b>AVERAGE</b> ?	0	1	2	3	4	5	6	7	8	9	10
Your pain intensity <b>RIGHT NOW</b> ?	0	1	2	3	4	5	6	7	8	9	10

Physician & Nursing Notes:      BP \_\_\_\_\_/\_\_\_\_\_      Pulse \_\_\_\_\_      Follow-Up in \_\_\_\_\_ Months

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

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De Wayde C. Perry, M.D