

|  |  |                   |     |                             |  |                         |               |
|--|--|-------------------|-----|-----------------------------|--|-------------------------|---------------|
| <b>LAST NAME</b>   |  | <b>FIRST NAME</b> |     |                             |  | <b>DATE</b> ___/___/___ |               |
| DATE OF BIRTH  |  | AGE               | SEX | APPOINTMENT TIME            |  | OR WALK-IN TIME         |               |
| ADDRESS  |  |                   |     | CITY/ZIP                    |  |                         |               |
| CELL PH #  |  |                   |     | EMAIL                       |  |                         |               |
| HAVE YOU REGISTERED ONLINE WITH THE STATE <b>YES</b> or <b>NO</b>                        |  |                   |     | MR IN HAND _____            |  | FILE _____              | OUTLOOK _____ |
| HAVE YOU BEEN EVALUATED AT OUR CLINIC BEFORE <b>YES</b> or <b>NO</b>                     |  |                   |     | HOW DID YOU HEAR ABOUT CMC? |  |                         |               |
| HAVE YOU BEEN ON THE COLORADO MEDICAL MARIJUANA REGISTRY BEFORE? <b>YES</b> or <b>NO</b> |  |                   |     |                             |  |                         |               |

|   |  |   |  |                                      |   |                               |                                   |                                 |                                   |                                   |                                   |  |                                 |
|---|--|---|--|--------------------------------------|---|-------------------------------|-----------------------------------|---------------------------------|-----------------------------------|-----------------------------------|-----------------------------------|--|---------------------------------|
| <b>IF SEVERE PAIN, CHECK ANY BOXES THAT MAY APPLY TO YOU</b><br><br><input type="checkbox"/> constant<br><input type="checkbox"/> daily<br><input type="checkbox"/> ___/7 days<br><input type="checkbox"/> ___ days/month<br><input type="checkbox"/> ___ days/year | <b>CHECK ANY BOXES THAT MAY APPLY TO YOU</b><br><br><input type="checkbox"/> HIGH CHOLESTERAL<br><input type="checkbox"/> HEART DISEASE<br><input type="checkbox"/> HIGH BLOOD PRESSURE<br><input type="checkbox"/> ADDICTION- PAST OR PRESENT | <b>CHECK ANY BOXES THAT MAY APPLY TO YOU</b><br><input type="checkbox"/> CURRENT OR ANY FAMILY HISTORY BIPOLAR<br><input type="checkbox"/> CURRENT OR ANY FAMILY HISTORY SCHIZOPHRENIA<br><input type="checkbox"/> SUICIDE ATTEMPT<br><input type="checkbox"/> HOSPITALIZED FOR MENTAL ILLNESS<br><input type="checkbox"/> CARDIOPULMONARY<br><input type="checkbox"/> LIVER OR RENAL DISEASE | <b>I AM CURRENTLY IN TREATMENT AND/OR HAVE BEEN DIAGNOSED WITH ONE OR MORE OF THE LISTED QUALIFYING MEDICAL CONDITION'S</b><br><br><b>CHECK ANY BOXES THAT MAY APPLY TO YOU</b><br><table style="width:100%;"> <tr> <td><input type="checkbox"/> SEVERE PAIN</td> <td><input type="checkbox"/> PERSISTENT MUSCLE SPASMS</td> </tr> <tr> <td><input type="checkbox"/> PTSD</td> <td><input type="checkbox"/> GLAUCOMA</td> </tr> <tr> <td><input type="checkbox"/> CANCER</td> <td><input type="checkbox"/> HIV/AIDS</td> </tr> <tr> <td><input type="checkbox"/> CACHEXIA</td> <td><input type="checkbox"/> SEIZURES</td> </tr> <tr> <td><input type="checkbox"/> SEVERE NAUSEA</td> <td><input type="checkbox"/> AUTISM</td> </tr> </table> | <input type="checkbox"/> SEVERE PAIN | <input type="checkbox"/> PERSISTENT MUSCLE SPASMS | <input type="checkbox"/> PTSD | <input type="checkbox"/> GLAUCOMA | <input type="checkbox"/> CANCER | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> CACHEXIA | <input type="checkbox"/> SEIZURES | <input type="checkbox"/> SEVERE NAUSEA | <input type="checkbox"/> AUTISM |
| <input type="checkbox"/> SEVERE PAIN  | <input type="checkbox"/> PERSISTENT MUSCLE SPASMS  |   |  |                                      |   |                               |                                   |                                 |                                   |                                   |                                   |  |                                 |
| <input type="checkbox"/> PTSD   | <input type="checkbox"/> GLAUCOMA  |   |  |                                      |   |                               |                                   |                                 |                                   |                                   |                                   |  |                                 |
| <input type="checkbox"/> CANCER   | <input type="checkbox"/> HIV/AIDS  |   |  |                                      |   |                               |                                   |                                 |                                   |                                   |                                   |  |                                 |
| <input type="checkbox"/> CACHEXIA   | <input type="checkbox"/> SEIZURES  |   |  |                                      |   |                               |                                   |                                 |                                   |                                   |                                   |  |                                 |
| <input type="checkbox"/> SEVERE NAUSEA  | <input type="checkbox"/> AUTISM  |   |  |                                      |   |                               |                                   |                                 |                                   |                                   |                                   |  |                                 |

**BRIEFLY DESCRIBE YOUR MEDICAL CONDNTIONS:**

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ARE YOU CURRENTLY PREGNANT OR NURSING \_\_\_\_\_ **YES** \_\_\_\_\_ **or NO**

**LIST ALL CURRENT MEDICATION (S) AND DOSAGE (S)**

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***I HAVE READ THE INFORMED CONSENT, UNDERSTAND AND ACCEPT ALL CONTAINED.***

**I HAVE RECEIVED THE LIST OF POSSIBLE RISKS ASSOCIATED WITH USING CANNABIS AND AGREE ALL THE INFORMATION HEREIN IS CORRECT. COHEN MEDICAL CENTERS AND ITS PROVIDERS RESERVE THE RIGHT TO REVOKE THIS MEDICAL MARIJUANA RECOMMENDATION.**

**PATIENT SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**\*\*\*\*\*DO NOT WRITE BELOW THIS LINE-----FOR CMC COLORADO ONLY\*\*\*\*\***

## **INFORMED CONSENT AND EVALUATION OF SUITABILITY FOR RECOMMENDATION OF MEDICAL MARIJUANA USAGE IN COLORADO**

I understand and agree that I am consulting with an Independent Contractor Physician at Cohen Medical Centers (CMC), for the sole purpose of an evaluation of my medical condition to obtain an opinion and counseling, as to whether or not I might benefit from the medical use of cannabis in connection with my chronic or debilitating disease or disabling medical condition as defined in the Colorado Medical Marijuana Amendment. The physician has based their opinion on the contemporaneous assessment of my medical history and current medical condition and is recommending and not prescribing medical cannabis. I understand and agree that the Independent Contractor Physician at CMC and or CMC is not in any way liable for my decision to use medical cannabis and if used is at my own risk.

In performing the evaluation of my medical condition as it relates to determining if I might benefit from medical use of cannabis, a bona fide physician-patient relationship for the sole purpose of fulfilling the physician's role in regulation the Colorado Medical Marijuana Amendment is established. This bona fide physician patient relationship is limited to the physician's role as defined in the Colorado Medical Marijuana Amendment and in no way can be construed to have formed a physician-patient relationship for any or all other purposes. The physician has advised me to consult with my primary care provider at least once a year to reevaluate my debilitating medical condition.

The physician has and will not provide any medical treatment, they are merely evaluating me to determine if, in their opinion, I have a chronic debilitating medical condition as defined in the Colorado Medical Marijuana Amendment, for which I might benefit from the medical use of cannabis. In the course of the evaluation, the physician will make a diagnosis and, if appropriate, provide me with general counseling about how patients with my condition can improve their symptoms. The physician has offered follow-up care to help me determine if cannabis is effective in treating my debilitating medical conditions.

If the physician's opinion is that I might benefit from the medical use of cannabis that opinion does not, in any way, imply that I have been advised to use cannabis. If I choose to use cannabis, I understand that cannabis may cause side effects, such as drowsiness, decreased coordination; and I must avoid hazardous activities, such as driving a vehicle, and operating heavy machinery when using cannabis. Patients, particularly those with heart conditions, cautioned that cannabis can increase heart rate and lower blood pressure that can cause you to get lightheaded and even pass out, particularly on standing. I agree the decision to use cannabis is at my sole discretion and once I have chosen to inhale, consume or any other form of ingestion of cannabis, the physician has advised me to assess the benefit I may receive from cannabis on an ongoing basis, and continue its use only if it is benefiting my symptoms. I agree that I should never drive a vehicle while using cannabis and that I can get a DUI for driving under the influence. I agree that using cannabis while under the influence of alcohol is **NOT** recommended. I understand the benefits and risks associated with the use of cannabis are not fully understood and the use of cannabis may involve risks that have not been identified. I accept all risk and agreed that CMC is not liable in any way and that we in no way imply or recommend that you purchase medicinal cannabis from any specific dispensary or caregiver. I also agreed I am not pregnant or breastfeeding.

My signature constitutes my legal name and acts as a notary journal of all legal Colorado Notary at CMC. The document being notarized is "PARENTAL CONSENT" MMR1004, Revised OCTOBER 2015. I also acknowledge I have freely sought out CMC, signed my name, provided my postal/email address, phone numbers, Legal ID in front of said notary. This information is at the sole discretion and ownership of CMC. CMC reserves the right to sell the medical centers in the future with no notice to me to include all email addresses and phone numbers. CMC has my permission to contact me by mail, email, phone and or text in regards to all matters.

WRITTEN OR EMAILED consent is REQUIRED by me for any CMC CONFIDENTIAL MEDICAL records to be made available. I understand and agree to inspection of any patient records by law enforcement officials in compliance with state and federal laws only.

Patient information will be kept confidential to provide services or to ensure that all administrative matters related to your care are handled appropriately. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left in administrative areas such as the front office, examination rooms, etc. These records will not be available to persons other than CMC.