Patient Information

Date: _____

Name of patient / applicant :_____

Name of guardian / individual completing this form: _____

Patient's Date of Birth: _____/_____/_____
Address:_____
City: _____ State: _____ Zip Code: _____

Home Phone: (_____) _____-_____
Cell Phone: (_____) _____-_____
Email:_____
Gender: ☐ Male ☐ Female
Social Security Number :_____ **Driver's License Number: _____**

How did you hear about UrbMD: Instagram ☐ Facebook ☐ Google ☐ Recertification ☐
Referred by _____ Other_____

Your Primary care physician information

Name:_____
Address:_____
City: _____ State:_____

Have you had a medical marijuana recommendation from a doctor before? Yes ☐ No ☐
If yes, please provide name of physician and/or practice
_____
_____

Have you been Diagnosed with Autism Spectrum Disorder Yes ☐ **No** ☐**, If yes, when were you diagnosed with Autism _____**

Have you had an IEP? Yes ☐ **No.** ☐ **, If Yes, please provide a copy of the last executed IEP.**

Are you or have you previously received any services for Autism? Yes ☐ **No.** ☐ **, If yes, please provide details of the services received and any documents from the service providers:**

_____

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SOCIAL / CULTURAL HISTORY:

Education Level: ☐ Elementary ☐ High School ☐ Vocational
Are there any vision problems that affect your communication?
Are there any hearing problems that affect your communication?
Are there any limitations to understanding or following instructions (either written or verbal)? ☐Yes ☐No
Current Living Situation (Check all that apply):
☐ Single Family ☐ Multi-generational Household ☐ Homeless Shelter ☐ Skilled Nursing Facility
☐ Other: _____

Circle any of the below conditions or symptoms associated with your Autism which are debilitating or cause significant disruption of daily living tasks or reduction of quality of life:

_____ Abdominal Pain / Frequent Cramps
_____ ADD/ADHD
_____ Anorexia with cachexia or Wasting Syndrome
_____ Anxiety Disorder
_____ Arthritis/ Chronic Musculoskeletar pain, cramps and weakness
_____ Asthma/ Breathing Problems
_____ Autoimmune Disease , Specify diagnosis _____
_____ Bipolar disorder
_____ Chronic fatigue
_____ Deficits in Social Communication and Interaction
_____ Depression
_____ Digestive Disorders, chronic constipation, Diarrhea bloating and Irritable Bowel Syndrome
_____ Dizziness
_____ Eating Disorder: Frequent nausea, extremely picky and selective texture preference, over eating
_____ Fainting
_____ Headaches
_____ Hyperactivity
_____ Hypersensitivity and Dysregulation with Loud Noises or Bright Lights or Strong Odors
_____ Insomnia or other sleeping disorders
_____ Itching and Chronic Scratching
_____ Intermittent Explosive Disorder (IED) causing trauma
_____ Mania
_____ Migraine Headache
_____ Muscle Spasm
_____ Muscular movement disorders
_____ Nausea
_____ Neuropathy
_____ Nightmares
_____ Numbness of hands or feet
_____ Obsessive Compulsive Disorder (OCD)
_____ Oral Dysesthesia and other sensory processing abnormalities
_____ Panic Attack
_____ Peripheral nerve pain
_____ Pervasive Developmental Disorder – Not Otherwise Specified (PDD-NOS)
_____ Repetitive Movement Disorder

_____ Restlessness
_____ Schizophrenia
_____ Seizures
_____ Severe Self-injurious Behavior (SIB)
_____ Spasticity
_____ Tourette's Syndrome
_____ Transition Difficulties
_____ Violent Outbursts Against Others including biting, hitting, pinching, throwing objects or food at others
_____ Vomiting

Other debilitating symptoms or conditions not mentioned above:
_____
_____

The symptom(s) (listed above) need to be significant to such an extent that one or more of a patient's major life activities is substantially limited.

- The term "major life activities" includes, but is not limited to, caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working. Mass. Gen. L. ch. 151B, section 1(20). Other examples of major life activities include sitting, standing, lifting and mental and emotional processes such as thinking, concentrating and interacting with others.

Past Surgical History

Please list any surgeries that you have had in the past. Include the reason, date, hospital and doctor who performed the surgery.

_____
_____

Medications:

Over the counter_____

Prescribed_____
_____

Chief Complaint

Please describe the medical condition(s) or complaints for which you are seeking a recommendation for medical marijuana. (How long have you had symptoms/diagnosis?)

Does this medical condition limit your ability to conduct major life activities? (Work, Eat, Sleep, Interact with others) Yes ☐ No ☐

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Do you feel that if this medical condition is not alleviated, it may cause serious harm to your physical or mental health, and safety? Yes ☐ No ☐

Are you currently receiving treatment/taking medication for the condition for which you are being evaluated for medical marijuana certification?
____ Yes ____ No What Treatment?_____

Activities of Daily Living Assessment:

Please check if any of the following activities are substantially limited (i.e. pain/weakness/impaired strength or ability) by the medical condition for which you seek medical marijuana certification?

____ caring for myself ____ hearing____ walking____ bending

____ performing manual tasks ____ eating____ standing____ speaking ____ seeing ____ sleeping

____ lifting ___ reading ____ communicating ____ operation of major bodily function

____ breathing ____ concentrating ____ working ____ learning____ thinking ____ social interaction

____ other (please specify) _____

Marijuana History:

Have you received medical care or evaluation by a physician/specialist for this medical condition?
Yes ☐ No ☐ **If yes**, please provide the **name**, **address** and **date last seen by the physician** (including chiropractor/acupuncture) that diagnosed and/or treated you for this medical condition/s:

_____

_____

If not listed, please describe all treatments that you have received to date for your current medical problems such as the medications prescribed, surgeries, physical therapy, acupuncture, homeopathy, or chiropractic care:

_____

_____

Have you received a recommendation or referral for medical marijuana by your physician to relieve or alleviate your debilitating conditions related to Autism Spectrum Disorder?
Yes No

Do you currently smoke **cigarettes**? Yes. No
Do you currently drink alcohol? Yes. No

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Do you have history of illicit drug use? Yes. No
Are you currently using any opioids? Yes No
Are you Currently Pregnant or nursing? Yes No

Do you currently use cannabis to treat your current medical condition? Yes. ☐ No ☐
At what age did you discover that cannabis eased your symptoms? _____

Does cannabis provide relief for your symptoms? Yes ☐ No ☐
If yes, please describe. (Example; less pain or nausea)
_____
_____

How often do you use marijuana: Daily Weekly. Monthly
How much cannabis do you consume per treatment? _____
What method do you currently use to consume the cannabis? (Please check all that apply)
Vaporize Ingest/edible Smoke Anointing oil

Have you had any negative/adverse reaction from use of marijuana?
_____ No ____ Yes (if yes, please describe)_____
_____

Additional Information

Please provide any other information you believe is relevant to the doctor's evaluation:
_____
_____
_____
_____

My signature below attests to the fact that I have accurately and completely disclosed the requested information and indicates that I give permission to UrbMD to verify my status as a patient who has consulted with UrbMD for the purpose of any certification that may be given with regard to the Humanitarian Medical Use of Marijuana. I do not waive any other patient and physician privacy rights under Federal HIPAA or Massachusetts State Laws.

Patient Signature_____ Date___/___/_____

Legal Guardian's Signature _____

RELEASE OF LIABILITY

I attest that the information on this form is correct and any medical history presented or discussed with the doctor is all 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 medical marijuana. Solely for verification purposes, I authorize Dr. Edwin Ishoo to converse regarding my medical condition.

I understand that I must be a Mass resident to obtain an approval or recommendation for the use of medical cannabis.

I affirm that I have a serious medical condition that negatively affects my quality of life. I have found or am interested in finding out whether or not medical marijuana provides substantial relief and improvement in my condition.

I understand that the cannabis plant is not regulated by the United States Food and Drug Administration and therefore may contain unknown quantities of active ingredients, impurities and /or contaminants. I understand the potential risks associated with an elevated daily consumption of medical marijuana including risks with respect to the effect on my cardiovascular and pulmonary systems and psychomotor performance, risks associated with the long-term use of marijuana are not fully understood and that the use of marijuana may involve risks that have not been identified. In requesting an approval or recommendation for the use of medical marijuana, I assume full responsibility for any and all risks involved in this action.

I have been advised that medical marijuana smoke contains chemicals known as tars that may be harmful to my health. Recent research indicates that vaporizing cannabis may eliminate exposure to tar. Should respiratory problems or other ill effects be experienced in association with its use, it should be discontinued and reported to the physician immediately.

I was also advised that the use of medical marijuana might affect my coordination and cognition in ways that could impair my ability to drive, operate machinery, or engage in potentially hazardous activities. I assume full responsibility for any harm resulting to me and/or other individuals as a result of my use of cannabis.

Massachusetts Medical Marijuana legislation

Provides for the possession of medical marijuana for the personal medical purposes of the patient with a physician approval or recommendation. It should be made clear that the physician, staff and representative of this practice are not providing medical marijuana, nor are they encouraging any illegal activity in my obtaining medical marijuana.

I, the undersigned, hereby request a consultation by the physician for the purposes of determining the appropriateness of medicinal marijuana treatment. I acknowledge that using cannabis as a medicine has been explained to me and that any questions that I have asked have been answered to my complete satisfaction. The physician, staff and representatives are addressing specific aspects of my medical care, and unless otherwise stated are in no way establishing themselves as primary care provider. Should an approval be made for my medicinal use of marijuana, I understand that there is a renewal date specified by the physician depending on the condition. I understand that it is my responsibility to see the physician to assess the possible continuance of cannabis use beyond the term of the approval.

Furthermore, the undersigned, or anyone acting on my behalf, hold the physician and his/her principals, agents and employees, free of and harmless from any liability resulting from the use of medical marijuana.

I further understand that by signing below, I am authorizing the release of any part of this record, except for identifying information, for use in data analysis of medical marijuana treated patients.

Patient and / or Legal Guardian name: _____ **DATE:** _____

Signature of Patient or Legal Guardian _____

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

AUTHORIZATION FOR USE/DISCLOSE OF PHI (Protected Health Information)

Patient Name: _____ **Date of Birth:** _____

Acknowledgement of Privacy Notice

I have received the practice's Notice of Privacy Practices. The Notice provides in detail the uses and disclosures of my PHI (Protected Health Information) that may be made by this practice. I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all PHI at, or controlled by, this practice. I understand I can obtain this practice's Notice of Privacy on request.

Authorization for Use/Disclosure of Protected Health Information (PHI)

I authorize the use and disclosure of all health information for the purpose of treatment, payment and Health Care Operations. I authorize UrbMD, Dr. Ishoo and staff to use these disclosures of my health information without limitation. I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected. I understand that any revocation does not apply to disclosures or use of PHI that have occurred prior to my revocation. In addition, I authorize disclosure of my PHI to the following individual(s):

_____

_____

_____

List any person(s) that you are allowing this office to communicate with regarding your PHI

Patient Manner of Contact

In general the HIPAA Privacy rule gives individuals the right to request a restriction on uses and disclosures of their PHI. I understand that verbal request is an acceptable authorization for the use of any alternate contact method, number and/or location as well as to change in the manner listed below (i.e. if patient leaves message with contact number and/or location, other than listed below). I understand that this practice calls to confirm appointments at the number I give.

**** I wish to be contacted in the following manner:**

_____ NO RESTRICTION (okay to contact home and/or work and leave detailed message)

_____ Restricted method of contact:

_____ Home ONLY - Message to return call to doctor's office

_____ Work ONLY - Message to return call to doctor's office

_____ Other _____

I understand that by signing this form I am confirming my receipt of the Notice of Privacy Practices; authorization for method of contact; and authorization for use and/or disclosure of my PHI.

Signature _____ **Date** _____

Relationship to patient, if signed by a personal representative, i.e. parent, legal guardian, etc.:

Relationship _____

Signature _____ **Date** _____