NURSES FOR SAFE ACCESS
A COLLECTIVE OF CARING NURSES

Members Medical Information, Cannabis Research and Data Collection Form

Name: _____ Date of Birth: _____Age: _____

Today's Date: _____ Email Address:_____

May we contact you by email? _____ Phone Number: _____

May we contact you by phone? _____ Street: _____ City: _____

State: _____ Zip Code: _____ Name of Next of Kin: _____

Phone Number Next of Kin: _____

Are you a new patient or is this a renewal? _____New _____Renewal

How did you hear about us? _____.

If Client is a Minor: Are you the "Legal Guardian" and can make this medical cannabis decision without a legal backlash and/ or custody issues from the other parent or legal guardian? Yes No

1. **Primary Caregivers Name**: _____Nurses For Safe Access

2. Medical Providers:

Please list all of the members of your medical treatment team

Name: _____ Phone #: _____

Name: _____ Phone #: _____

Name: _____ Phone #: _____

Name: _____ Phone #_____

Name: _____ Phone#:_____

3. Chief Complaint:

What is your current debilitating medical condition?_____

_____

_____

4. MEDICAL INFORMATION – Include ICD-10 codes where appropriate.

Primary Diagnosis: _____. ICD-10 _____ Date of onset:_____

Secondary Diagnosis: _____. ICD-10 _____ Date of onset:_____

Other Diagnosis: _____. ICD-10 _____ Date of onset:_____

Other Diagnosis: _____. ICD-10 _____ Date of onset:_____

Other Diagnosis: _____. ICD-10 _____ Date of onset:_____

Other Diagnosis: _____. ICD-10 _____ Date of onset:_____

Other Diagnosis: _____. ICD-10 _____ Date of onset:_____

Other Diagnosis: _____. ICD-10 _____ Date of onset:_____

Allergies: _____

5. Pharmaceutical Medication: List all medication taken on a routine basis:

Medication:_____ Dose:_____ Route:_____ Frequency:_____

Medication:_____ Dose:_____ Route:_____ Frequency:_____

Medication:_____ Dose:_____ Route:_____ Frequency:_____

Medication:_____ Dose:_____ Route:_____ Frequency:_____

Medication:_____ Dose:_____ Route:_____ Frequency:_____

Medication:_____ Dose:_____ Route:_____ Frequency:_____

Medication:_____ Dose:_____ Route:_____ Frequency:_____

5. Pharmaceutical Medication continued

Medication:_____ Dose:_____ Route:_____ Frequency:_____

Medication:_____ Dose:_____ Route:_____ Frequency:_____

Medication:_____ Dose:_____ Route:_____ Frequency:_____

6. Cannabis Medication: List all cannabis medication taken on a routine basis: Manufactures name of all cannabis products:

Medication:_____ Dose:_____ Route:_____ Frequency:_____

Medication:_____ Dose:_____ Route:_____ Frequency:_____

Medication:_____ Dose:_____ Route:_____ Frequency:_____

Medication:_____ Dose:_____ Route:_____ Frequency:_____

Medication:_____ Dose:_____ Route:_____ Frequency:_____

Medication:_____ Dose:_____ Route:_____ Frequency:_____

Medication:_____ Dose:_____ Route:_____ Frequency:_____

Medication:_____ Dose:_____ Route:_____ Frequency:_____

Medication:_____ Dose:_____ Route:_____ Frequency:_____

7. **Herbal, Vitamins And Nutritional Supplements:**

Supplements:_____ Dose:_____ Route:_____ Frequency:_____

Supplements:_____ Dose:_____ Route:_____ Frequency:_____

Supplements:_____ Dose:_____ Route:_____ Frequency:_____

Supplements:_____ Dose:_____ Route:_____ Frequency:_____

Supplements:_____ Dose:_____ Route:_____ Frequency:_____

Supplements:_____ Dose:_____ Route:_____ Frequency:_____

Supplements:_____ Dose:_____ Route:_____ Frequency:_____

Supplements:_____ Dose:_____ Route:_____ Frequency:_____

Supplements:_____ Dose:_____ Route:_____ Frequency:_____

8. **Nutritional Lifestyle**

Vegan (Type)_____

Meat eater frequency _____ Type_____

Diet:_____

_____

_____

9**. Which of the following treatments have you tried in the past to treat your debilitating medical condition? (please *check* all that apply):** ◯ **Medications** ◯ **Herbs** ◯ **Surgery** ◯ **Injections** ◯ **Physical therapy** ◯ **Naturopathic care** ◯ **Chiropractic** ◯ **Acupuncture** ◯ **Homeopathy** ◯ **Counseling** ◯ **Stretching exercises** ◯ **Dietary changes**

Other: _____

10**. Do you believe that if your symptoms are not alleviated that your safety, your physical health, or your mental health are at risk of further harm?** ◯ **Yes** ◯ **No**

11**. Please *Check* any of the activities that are limited because of your debilitating medical condition**:

Self Care ◯ **Performing manual tasks** ◯ **Seeing** ◯ **Hearing** ◯ **Eating** ◯ **Sleeping** ◯ **Walking** ◯ **Standing** ◯ **Lifting** ◯ **Bending** ◯ **Speaking** ◯ **Breathing** ◯ **Learning** ◯ **Reading** ◯ **Concentrating** ◯ **Thinking** ◯ **Communicating** ◯ **Working** ◯ **Immune system function** ◯ **Digestive function** ◯ **Endocrine function** ◯ **Reproductive function** ◯ **Sexual function** ◯

12 Cannabis Use:

Have you used cannabis in the past: ◯ **Yes** ◯ **No**

At what age did you first ever try cannabis? _____ N/A

When did you begin using it medicinally? _____Why_____

What methods of consumption of cannabis do you use? **Smoke** ◯ **Vaporizer** ◯ **Edibles** ◯**Oils** ◯**Tincture** ◯**Tea** ◯

Salve ◯ **Raw** ◯

How much cannabis do you typically use in a day? (a large joint is about one gram)

_____

On a scale of 0 - 10, how effective is cannabis at relieving the symptoms of your condition? _____

Explain:_____

When taking Cannabis do you decrease your opiate pain relievers' usages? ◯ YES ◯ NO

Explain:_____

Have you ever tried prescription THC (Marinol/Dronabinol)? ◯ YES ◯ NO

Explain:_____

Has cannabis ever made you suicidal, homicidal, violent or psychotic? ◯ YES ◯ NO

Explain:_____

Have you ever lost friends or family over cannabis use? ◯ YES ◯ NO

Explain:_____

What bothersome side effects have you ever had from using cannabis?

Explain:_____

Have you ever been in treatment for cannabis addiction? ◯ YES ◯ NO

Explain:_____

Has anyone expressed concern that you might be using cannabis for uses that are not medicinal? ◯ YES ◯ NO

Explain:_____

Have you ever promised someone that you would quit or cut down and failed to do so? ◯ YES ◯ NO

Cannabis Use:

Explain:_____

Have you ever used cannabis to help with addiction to alcohol, tobacco, or other medicines? ◯ YES ◯ NO

13. Please describe, in detail, how cannabis helps to treat your debilitating medical conditions;

14. **Past Medical History: Please check off any of the medical problems that you have had in the past:**

AIDS/HIV ○ **Alcoholism** ○ **ALS** ○ **Alzheimer's** ○ **Anaphylaxis** ○ **Anemia** ○ **Angina** ○ **Arthritis** ○

Asthma ○ **Back Pain** ○ **Bulimia** ○ **Cancer** ○ **Chest Pain** ○ **Chronic Pain** ○ **Crohn's** ○ **Depression** ○ **Diabetes** ○ **Diarrhea**

Fainting spells ○ **Glaucoma** ○ **Headaches** ○ **Heart Problems** ○ **Hepatitis** ○ **Hypertension** ○ **Insomnia** ○ **Kidney Issues**

Leukemia ○ **MS** ○ **Neck Pain** ○ **Opioid Addiction** ○ **Pain** ○ **PTSD** ○ **Seizures** ○ **Stroke** ○ **Suicide Attempt** ○

Tingling in hands or feet ○

Other:_____

Past Surgical History : Please list all major surgeries that you have had: _____

_____

_____

_____

15. Personal Social History:

Do you currently: smoke cigarettes? ○ **Yes** ○ **No** Use alcohol? ○ **Yes** ○ **No** Heroin? ○ **Yes** ○ **No**

Cocaine? ◯ **Yes** ◯ **No**

Are you on probation? _____ Do you have any active legal issue such as CPS involvement, a divorce in progress

Yes No If yes, explain:_____

Marijuana charge? _____

What type of work do you do? _____

>>>>>>>>>>>>>>> **For Nurses For Safe Access Personnel To Fill Out** <<<<<<<<<<<<<

Plan Of Care:

*** Continue All Pharmaceutical Medication As Prescribed by your Physicians**

Cannabis Medication:

Medication:_____ Dose:_____ Route:_____ Frequency:_____

Medication:_____ Dose:_____ Route:_____ Frequency:_____

Medication:_____ Dose:_____ Route:_____ Frequency:_____

Medication:_____ Dose:_____ Route:_____ Frequency:_____

Medication:_____ Dose:_____ Route:_____ Frequency:_____

Medication:_____ Dose:_____ Route:_____ Frequency:_____

Medication:_____ Dose:_____ Route:_____ Frequency:_____

Herbal Blends, Vitamins & Nutritional Supplements

Supplements:_____ Dose:_____ Route:_____ Frequency:_____

Supplements:_____ Dose:_____ Route:_____ Frequency:_____

Supplements:_____ Dose:_____ Route:_____ Frequency:_____

Supplements:_____ Dose:_____ Route:_____ Frequency:_____

Supplements:_____ Dose:_____ Route:_____ Frequency:_____

We are required to give you a notice of our privacy practices under HIPPA that informs you of how we may share your health information for our cannabis research and data collection. We would like for you to summit MRI's Cat Scans, Pet

Scans or any other Western test results you deem suitable for our research study. This notice is in your intake packet and you are free to read it, review it, ask questions about it and take it home with you. We are required to document that you have been given this notice. In addition, the form also contains a copy of our member agreement. By signing below you acknowledge that you have agreed to supply NFSA personal health data and test results for our study that NFSA will keep all of your data secure in a HIPPA compliant software program

Signature: _____ Date: _____

Attention!

I certify that this is an adult patient (over 18 years of age/ or with an accompanied legal guardian) with whom I have a bona fide collective member and/or caregiver relationship. I have reviewed recommendation letter and confirmed the expiration date has not expired. I have reviewed the risks of using cannabis for medical reasons with my patient and or patient's legal guardian and they have demonstrated the understanding of the risk by asking appropriate questions .

Date of Service: _____

Member Signature: _____

Signed: Nurse/ NFSA Care Giver Provider _____