Medical Marijuana Group
PO Box 20070
RPO Edward Street
St. Thomas, ON
N5P 4H4

P: 1-844-444-4664
F: 1-833-222-2664
E: info@medmg.ca

Patient Information

First Name: _____ Middle Name: _____
Preferred Name: _____ Last Name: _____
Date of Birth (YYYY/MM/DD): _____/_____/_____
Gender: ☐ Male ☐ Female ☐ Other
Address: _____
City: _____ Province: _____
Postal Code: _____ Phone: _____
Email: _____
Health Card #: _____
Are you FNMI (First Nations, Metis, Inuit)? ☐ Yes ☐ No

Physician Assessment

I'm seeking cannabis to treat: _____

_____

This symptom prevents me from being able to: _____

_____

If you have used medical cannabis previously, how has it helped to alleviate the symptoms above? _____

_____

Has medical cannabis helped lower the dose of any other medications? If yes, please list the medications. _____

_____

Known allergies to medications and reactions: _____

_____

Treatment Information

List all past and current treatments to treat the symptom(s) above pertaining to seeking a cannabis prescription. This includes all prescription medications, any over-the-counter treatments, herbal treatments, physio, chiro, massage therapy, etc. Please comment on the effectiveness of the treatments and side effects (where applicable).

PAST TREATMENT(S), DATE(S) STOPPED:

1 _____
2 _____
3 _____

CURRENT TREATMENTS:

1 _____
2 _____
3 _____

Emergency Contact

First Name: _____ Last Name: _____ Relationship: _____
Phone: _____ Email: _____
I give MMC consent to speak to this person about my cannabis treatment. ☐ Yes ☐ No

Accident Benefits Information

Insurer: _____ Date of Accident (MM/DD/YYYY): _____/_____/_____

Adjuster: _____ Claim #: _____ Policy #: _____

Phone: _____ Fax: _____

Lawyer Information

Law Firm: _____ Lawyer: _____

Clerk (Full Name): _____ Phone: _____

Primary Care Physician Information

Name: _____

Phone: _____ Fax: _____

Additional Treatment Providers

Name: _____

☐ Occupational Therapist ☐ Physio/Chiro/Massage ☐ Case Manager

Phone: _____ Fax: _____

Name: _____

☐ Occupational Therapist ☐ Physio/Chiro/Massage ☐ Case Manager

Phone: _____ Fax: _____

Extended Health Insurance

Primary Benefits Provider (if applicable): _____

Carrier/Branch Number: _____ Policy/Plan Number: _____

ID/Certificate Number: _____

Extended Health Insurance (continued)

Secondary Benefits Provider (if applicable): _____

Carrier/Branch Number: _____ Policy/Plan Number: _____

ID/Certificate Number: _____

Please complete if benefits are through your spouse:

Spouse's Name (Full Name): _____

Spouse's Date of Birth (YYYY/MM/DD): _____/_____/_____

Products and Services		**Please select all that apply.**
Cannabis Products	**Compounded Pain Creams**	**Services**
☐ Dry Cannabis	☐ Joint and Inflammation	☐ Compassionate Pricing
☐ Milled Cannabis	☐ Neuropathic Pain	☐ Coverage
☐ CBD Oil	☐ Migraines	☐ Veteran Benefit Support
☐ THC Oil	☐ Muscle Relaxant	☐ MVA Claims/Treatment Plans
☐ 1:1 Oil	☐ Muscle & Soft Tissue Pain	☐ Cannabis ID Card
☐ Capsules		☐ Pharmacy Delivery
☐ Sublingual Sprays		☐ Nursing Home Advocacy

MMG CORP
medical marijuana group

TREATMENT AGREEMENT

I, _____ (first and last name), understand that this Treatment Agreement contains important information about medical cannabis that the assessing physician requires and that I acknowledge and understand before they may issue a prescription and/or authorization for the use of medical cannabis.
I agree not to seek medical cannabis treatment from additional physicians or illegal sources (i.e. dispensaries, compassion clubs, etc.) while being prescribed by the assessing health care practitioner.
I agree to only use my medical cannabis as prescribed by the assessing physician, including storing it in a safe and secure location.
I understand that I am subject to random urine toxicology screening throughout the duration of my prescription and failure to comply with these screenings mat result in a discontinuation of my prescription. I also understand that I am not to be using illicit substances while prescribed medical cannabis by the assessing physician.
I agree to not sell or distribute my medical cannabis.
I understand that if this agreement is breached in part or its entirety, the assessing physician may discontinue my prescription for medical cannabis. I have not been coerced to sign this consent and am signing this form under my own free will.

Signature: _____ Date (YYYY/MM/DD): _____/_____/_____

CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION

I, _____ (first and last name), acknowledge, agree, and/or grant permission to Medical Marijuana Group to access my prescription, medical documents, and/or personal health information, which may consist of dosing information of topical compound creams and/or cannabis used for medical purposes, which is used as verification of the healthcare practitioner's order required by a physician, pharmacy, or licensed producer.

I grant permission to the pharmacy or licensed producer of my choosing, specified on the prescription or medical documents, to share my application and related materials with your insurance provider including recommended dose information for the purpose of facilitating direct billing for insurance purposes. I also grant the pharmacy or licensed producer permission to disclose personal and sales-related information to Medical Marijuana Group for tracking and information purposes.

I acknowledge the indications, safety, and understand that the risks of dried cannabis use has not been adequately studied and that the appropriate dose is unclear and may vary person to person. I acknowledge that any medical cannabis product obtained from a licensed producer is done so at my own risk and I release Medical Marijuana Group from all and any actions, claims, complaints, and demands for damages, loss, or injury whatsoever, arising directly or indirectly as a consequence of the use of medical cannabis products.

I understand that the purpose of disclosing this personal health information to the company noted above is in order to provide products or services offered by Medical Marijuana Group. I understand that I can refuse to sign this consent form. I have not been coerced to sign this consent form and am signing this form under my own free will.

By my signature below, I certify that the information on this form and in connection with my registration, is true and accurate. I acknowledge that I am responsible for the information that I provided and any costs associated with providing false information.

Signature: _____ Date (YYYY/MM/DD): _____/_____/_____