Alternative Medications Evaluation Record

PATIENT SECTION

Name		Date of Birth		Today's Date	

Write the reason/s you believe you qualify to receive alternative medications:

Write any medical problems or surgeries you have now, or had in the past:

Write the names of the medicines you take:

PHYSICIAN SECTION

Physical Examination Abnormality/s

HEENT	ABN	Neck	ABN	Mid Back	ABN	Low Back	ABN	Shoulders	R L
Upper Arms	R L	Elbows	R L	Forearms	R L	Wrists	R L	Hands	R L
Hips	R L	Upper Legs	R L	Knees	R L	Lower Legs	R L	Ankles	R L
Feet	R L	CNS	ABN	Skin	ABN	Chest	R L	Abdomen	R L
MSE	abn	Normal		Comment					

Is the patient's examination consistent with their medical history and requested reason for consideration?

YES		No	

Records reviewed?

Yes		If no, why not?	

Certification approval granted?

YES		No	

1. The patient was instructed that alternative medications may include a controlled substance and is to be used for medicinal purposes only. It is not to be shared, distributed, or sold.
2. The patient was instructed that alternative medications affect individuals differently. For safety reasons, they were instructed not to use these medications when driving, operating heavy machinery, or near water, hot surfaces, etc.

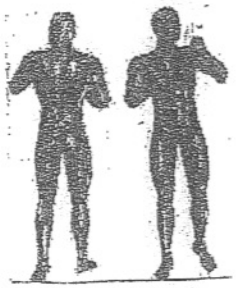
Qualifying condition/s:

Physician Name		Physician Signature	

PATIENT'S HISTORY AND PHYSICAL

Date = = 201

Mr/Ms_____ DOB_____ Age_____ yrs



Circle the symptoms/diseases you are having

1.Sever and persistent Muscle spasms (including M.S.)= yes / no

If yes then where_____

2.Sever and Chronic pain - on scale of 0 to 10 = 3 5 7

(i). **Circle below and in picture pain area** Wt. Ht.

Shoulder		elbow		wrist		hand		hip		knee		ankle		foot		arm		leg	
Rt	Lt	Rt	Lt	Rt	Lt	Rt	Lt	Rt	Lt	Rt	Lt	Rt	Lt	Rt	Lt	Rt	Lt	Rt	Lt

(ii) Pain on rest / movements How many years _____How many hrs a day_____

(Iii) Pain at neck area on bending turning, flexing, extending _____years_____hrs/day

(iv) Pain at back area on bending, lifting, pushing, walking, Standing _____yrs_____hrs/day

(v) Pain feels like (Circle)- weakening tiring exhausting draining
fatiguing wearing sapping incapacitating enervating disabling

(vi) Symptoms affecting what activities in daily life_____

(vii) Any accident (type/year)_____Sports injury (type/year)_____

(viii) Any x Ray scan. MRI done when and where and what was told_____

(ix) Treatment last few months/years taken (chiropractor, physical therapy etc)_____

(x) Name Medications taken_____

(xi) Relief- yes/ no / some relief, Last time saw MD/ ER (name and when)_____

3. Cancer, Glaucoma, HIV, Hepatitis C, Amy. Lateral sclerosis, Crohn's disease, Agitation (Alzheimer's), Nail patella, Cachexia or wasting syndrome, Seizures, severe and persistent muscle spasm YES / NO- describe if yes and since when_____

4. Smoking /day Drinking times/week, name all surgeries done/yr_____

5. **Circle if you have and since when** Diabetes, Overweight, Asthma, COPD, High B.P.

High cholesterol- Arthritis, Psych problems and Any other problems_____

Patient's Consent for Health Care Services & Agreement for Debilitating condition and Pain Treatment

Patient's name _____M /F DOB_____

(1).Consent for Examination - I hereby consent and authorize the concerned doctor / health organization to provide me health care services (history, physical, advice and for billing) as needed. I also consent to let the concerned doctor/ health organization treat me for my serious debilitating medical condition for which I'm here. Doing so, through the use of alternative medical treatment methods provided during the course of an ongoing bonafide physician-patient relationship. I have been informed about the privacy practices act (HIPPA) and my rights also have been explained to my full satisfaction. At present I wish to be assessed for eligibility of use of alternative medications for my debilitating condition. I understand that any fee charged for services is non-refundable.

(2).Medications use– My medications including controlled substances if taken (preferred to be from one physician and one pharmacy) have been reviewed. I have been instructed about the advantage, disadvantages, alternatives, potential adverse effects and expected response to treatment for alternative medications and for other controlled substances as well. I have been instructed on the proven and unproven effects on immunity, hormones, neuro-skeletal muscular and other systems. I have been informed that the operation of machinery or driving of a vehicle under the influence is prohibited. I have been also informed about Tylenol/ Acetaminophen's chronic use having great potential of causing cirrhosis of liver.

(3).Plan of care and goal of therapy- I have been advised of any diagnostic tests to be done for confirmation of the disease process or its progress, and to follow up with other treating physicians and specialists as required.The goal is to get relief of symptoms, treatment / cure of the disease and thus to consider all options in therapy. I have been informed and instructed to my satisfaction and I understand that I am free to ask again any time, if needed.

(4).Periodic follow up- I will also follow up periodically with the physician for my illness and effects from any alternative medications and will inform the physician when I will not be in further need of alternative medications for my debilitating medical conditions.

(5).Violation of agreement-(Denial of controlled substances)-I agree that in case of a violation of this consent and agreement and as a result of any violation I will not be given any controlled substances or alternative medications and may have to find another MD.

I declare under penalty of perjury and fraud that all information and assertions (including medical reports if any) made by me about my health condition including for my debilitating status of symptoms or disease are true and correct. I agree to hold the physician harmless in all aspects and I myself will be totally responsible for taking due care and following up with the diagnosis given to me in reference to my health care.

_____Signed by patient Date - -201

Patient's information

Copy of ID card /driving license and insurance cards

Name_____Date of birth_____

Social Security #_____Tel_____

Address if different than above_____

_____

Insurance (Medicare) information Group ID _____

_____

Sign_____

Record Release Authorization

Date - - 2014

To_____

_____

I authorize and give consent to doctor (name and address below) under whose treatment I am now to receive my- all medical information from you including consultations-

(1) History –physical examination/consultation summary findings.

(2) Diagnostic tests reports (blood tests, X Rays, Scans, MRI etc).

(3) Name of all currently prescribed meds.

(4) Last visit's date and summary.

I will assume that by this authorized letter, you will send these health related documents to the address given below including acknowledgement of this letter for the above at the earliest.

Patient's name_____ Sign_____

DOB_____ Telephone #_____

Address_____

From-
4955 N. Milwaukee Avenue
Chicago IL 60630
TEL (847) 656-5345
FAX (312) 674-7584

CONTRADICTIONS AND SIDE EFFECTS ACKNOWLEDGMENT

I understand that cannabis (marijuana) may affect or impair: my coordination and cognition, as well as my ability to drive, operate heavy machinery and/or engage in potentially hazardous activities.

Vaporizers may substantially reduce many of the potentially harmful smoke toxins that are normally present in marijuana smoke, because although smoking cannabis (marijuana) has not been linked to lung cancer, smoking it can cause respiratory harm, such as bronchitis. Many researchers agree that marijuana smoke contains known carcinogens (chemicals that can cause cancer) and that smoking marijuana may increase the risk of respiratory diseases and cancers of the lungs, mouth and tongue. Cannabis (marijuana) smoke contains chemicals known as tars that may be harmful to my health.

I understand that side effects, while rare, may occur while I am taking medical cannabis (marijuana). These side effects have been explained to me.

Side effects of medical cannabis (marijuana) can include, but are not limited to:

- Anxiety
- Inability to concentrate
- Difficulty in completing complex tasks
- Sedation
- Alterations in the perception of time and space
- Impairment of motor skills, reaction time and physical coordination
- Low blood pressure. .
- Dizziness
- Increased talkativeness
- Impairment of short-term memory
- Confusion
- Euphoria
- Tachycardia (fast heart beat) and heart palpitations
- Paranoia
- Suppression of the body's immune system
- Psychotic symptoms (*e.g.*, delusions, hallucinations)

The potency and effects of cannabis (marijuana) varies. Estimating the proper marijuana dosage is very important. Symptoms of withdrawal, while generally mild, can include:

- Nausea
- Vomiting
- Disturbances to heart rhythms and numbness in the limbs.
- Hacking cough

For some patients, chronic marijuana use can lead to laryngitis, bronchitis and general apathy. I understand that some patients can become dependent on marijuana and could experience withdrawal symptoms when they stop. Symptoms of withdrawal, while generally mild, can include:

- Feelings of depression, sadness or irritability
- Insomnia
- Sleep disturbances
- Unusual tiredness
- Trouble concentrating
- Loss of appetite

I understand that the cannabis plant is not a food crop and therefore is not regulated by the U.S. Food and Drug Administration and may contain unknown quantities of impurities, active ingredients and/or contaminants. While under the influence of marijuana, the use of alcohol is not recommended. The possibility exists that cannabis (marijuana) may exacerbate schizophrenia in persons predisposed to that disorder, although marijuana does not produce any known psychosis.

Patient's Name (Please Print) Patient's Signature Date

Progress Notes

PATIENT NAME	☐ F ☐ M	BIRTHDATE	PAGE

DATE	Important: Please date and initial every entry.

Progress Notes