TEXAS INTEGRATIVE CANNABIS CLINIC

INTAKE FORMS FOR
NEW MEDICAL CANNABIS PATIENT

Revised 1/1/2025

IMPORTANT: All of the pages must be completed prior to receiving prescriptions of medicinal cannabis. If you have any questions regarding these documents, please contact us so we may assist you. Not completing these forms may result in a delay of receiving the medicinal cannabis.

This intake form is for individual candidates considering the use of medical cannabis products for treatment of one or more medical conditions. Please provide all the information requested on these forms.

(PLEASE PRINT CLEARLY)

Date_____

Name (as it appears on drivers license)

_____

DOB_____

Address_____

City/Town_____

State_____ **Zip Code**_____

Height_____ **Weight**_____

SSN #_____ **Phone #**_____

Email address_____

Name of legal guardian and person you wish to have access to your information or allowed to pick up your Cannabis as it appears on drivers lic.,_____

Address_____

City/Town_____

State_____ **Zip Code**_____

Phone #_____ **Last 5 of SS#**_____

Email address_____

Provide the reason you are seeking treatment with cannabis products (Select all that apply)

❑ **Neuropathy** ❑ **Muscle Spasms** ❑ **Cancer**

❑ **Pain associated to neuropathy or Muscle Spasms**

❑ **PTSD** ❑ **Dementia** ❑ **Parkinsonism**

❑ **Degenerative nerve conditions** ❑ **Other** _____

Provide a brief description of other conditions:

_____

Please provide any signs or symptoms you are experiencing, provide the approximate date of onset, frequency, severity and how it is disabling.

_____

_____

_____

Please provide any treatments you have attempted for the conditions listed above. Please provide result outcomes, duration and unwanted effects of the treatments.

_____

_____

_____

Please list all medical conditions you have been diagnosed with.

_____

_____

_____

If you consume or use the following, please provide the amount and frequency;

Caffeine_____

Alcoholic beverages_____

☐ Tobacco ☐ Vape ☐ Smoke ☐ Oral ☐ Snuff ☐ Hookah

Frequency/Amount: _____

Supplements

_____

_____

List all prescriptions and over the counter medications you take. Provide the dosage and frequency

_____

_____

_____

_____

Please list any Allergies, include foods, plants, pollens, medications and any other allergy known to you

_____

_____

Date _____

Signature of patient _____

Signature of patients guardian _____

Healthcare Proxy/power of attorney signature

_____

TEXAS INTEGRATIVE CANNABIS CLINIC

MEDICAL CANNABIS
Consent Form

A qualified physician is prohibited to delegate the responsibility of obtaining written informed consent to another person. A patient which has qualified for medicinal cannabis must sign and initial the sections. If a person is a minor or has a legal guardian, the sections must be signed and initial as requested by the legal health care proxy. The registered physician will also sign and date the document.

I_____(patients printed name). Understand that Medical Cannabis is offered as treatment for specific medical conditions and/or symptoms as designated by the Texas Department of Public Safety Compassionate Use Program.

PLEASE INITIAL EACH SECTION

____I understand that Dr. Rogelio Trevino is a qualified physician who is registered with the Texas Department of Public Safety Compassionate Use Program and may recommend and prescribe cannabis including but not limited to medical marijuana for qualified medical conditions.

____I understand that Dr. Rogelio Trevino is not implying or suggesting that medical cannabis should be a substitute for any other treatment or prescribed remedy from other physicians.

____I understand that I may not seek medical cannabis from any other sources while registered with Dr. Rogelio Trevino.

____Medical marijuana is not regulated by the USFDA and therefore may have additional by-products which may not have been studied in a clinical setting and therefore not approved by the USFDA.

____I am aware that a notice of compliance has not been issued under the Food and Drug Administration's regulations concerning the safety and effectiveness of marijuana as drug. I understand the significance of this fact.

____ I am aware that medical marijuana has not been approved under federal regulations, and I understand that medical marijuana has not been deemed legal under federal law.

____I understand the benefits and risks associated with use of marijuana products are not fully understood and that the use of marijuana may involve risks that have not been identified. I accept such a risk.

____I agree that if I am a female patient that I will contact the prescribing provider if I become or consider becoming pregnant. I acknowledge that the use of medical marijuana creates a pass through effect problems to a fetus during pregnancy and during breast feeding.

____I should not drive a vehicle while using medical marijuana and that I can get a DUI for driving under the influence.

____I understand that Dr. Rogelio Trevino will register my case with the Texas Department of Public Safety Compassionate Use Program Registry. He will provide a treatment plan with quantity, frequency to be prescribed. Dr. Rogelio Trevino is required to assess for unwanted effects and positive results from the use of medical marijuana.

____I understand that I will contact a Texas Medical Marijuana dispensary that is registered with the Texas Compassionate Use Program. The dispensary will download the prescription held at the Texas Department of Public Safety State registry to fill the medical marijuana prescription. The dispensary is required to deliver the prescription and allow you to pick up the prescription at the dispensary.

_____I understand that when treatment is discontinued, Dr. Rogelio Trevino will deactivate my registration with the Texas Department of Public Safety Compassionate Use Program.

_____I understand Federal law prohibits the use, distribution, possession and manufacturing of marijuana and products. Texas law has modified their state laws to allow certain medical conditions to be treated with medical marijuana.

_____I understand that the Federal Government classifies marijuana as an illegal substance including the use marijuana for medical illnesses.

____I understand that marijuana has a potential for addiction. Studies indicate that individuals may develop a tolerance to, dependence on, or addiction to marijuana. I agree to contact Dr. Rogelio Trevino if I feel I am developing an unwanted dependence on medical marijuana.

____I understand that there is a potential effect that medical marijuana has on patients' ability on coordination, ability to operate heavy machinery, a motor vehicle, and engage in activity that require high levels of alertness.

____Marijuana has not been approved by the Food and Drug Administration for marketing as a drug. Therefore, the "manufacture" of marijuana for medical use is not subject to any federal standards, quality control, or other oversight. Marijuana may contain unknown quantities of active ingredients., which may vary in potency, and substances in addition to THC, which is the primary psychoactive chemical component of marijuana.

____I understand there are potential unwanted effects of medical marijuana. Some of these effects include but are not limited to the following : Dizziness, anxiety, confusion, sedation, low blood pressure, impairment of short term memory, euphoria, depression, inability to concentrate, restlessness and insomnia. Marijuana may worsen depression, schizophrenia, paranoid behavior and alters time and space coordination. Long term use of marijuana is not fully understood and may lead to chronic effects and some may be irreversible.

____I understand that abrupt discontinuation of medical marijuana may result in withdrawal symptoms and a rebound effect.

____I understand that using alcohol or any other substance that depresses central nervous system function is not recommended or advised.

____ I agree to inform Dr. Rogelio Trevino if I experience any unwanted effects from medical marijuana including but not limited to the mentioned above.

___. I agree to contact Dr. Rogelio Trevino if I experience a change in mood or behavior. If I become depressed or psychotic or bizarre thoughts , have suicidal thoughts, or experience crying spells. I will also contact Dr. Rogelio Trevino if I experience change in breathing, change in sleeping patterns, extreme fatigue or change in motivation, change in spirituality, withdrawal from friends or family or social life.

____Signs of withdrawal can include; feelings of depression, sadness, irritability, insomnia, anxiety, restlessness, agitation, loss of appetite, trouble concentrating, sleep disturbances and fatigue.

____I understand that the use of medical marijuana through the Texas Compassionate Use Program may not protect against occupation policies against the use of marijuana products and testing may occur.

THE RISK, BENEFITS, AND DRUG INTERACTIONS OF MARIJUANA

____Signs of withdrawal can include: feelings of depression, sadness, irritability, insomnia, restlessness, agitation, loss of appetite, trouble concentrating, sleep disturbances and unusual tiredness.

____Symptoms of marijuana overdose include, but are not limited to, nausea, vomiting, hacking cough, disturbances in the heart rhythms, numbness of hands, feet, arms or legs, anxiety attacks and incapacitation. If I experience these symptoms, I agree to contact Dr. Rogelio Trevino , discontinue the medication and go to the emergency room.

____Numerous drugs are known to interact with marijuana and not all drug interactions are understood or Known. Some mixing of medications can lead to serious and even fatal consequences. I agree to following directions of Dr. Rogelio Trevino regarding the use of prescription and non-prescription medication. I will advise any other of my treating physicians of my use of medical marijuana.

____Marijuana may increase the risk of bleeding, low blood pressure, elevated or decreased blood sugars, abnormal liver enzymes and enzyme inhibition and induction, if any symptoms or signs develop go to the emergency room and contact Dr. Rogelio Trevino.

____I understand that medical marijuana may have serious risks and may cause low birthweight, or other abnormalities in embryos, fetuses and newborns.

____I have had the opportunity to discuss these matters with the physician and to ask questions regarding anything I may not understand or that I believe needed to be clarified. I acknowledge that Dr. Rogelio Trevino has informed me of the nature of a recommended treatment, including but not limited to, any recommendation regarding medical marijuana.

BY SIGNING THIS DOCUMENT, I VOLUNTARILY AGREE THAT ALL MY QUESTIONS HAVE BEEN ADDRESSED ; BENEFITS AND RISK HAVE BEEN DISCUSSED . I UNDERSTAND NO FEES ASSOCIATED WITH CARE OR OBTAINING MEDICAL CANNABIS CAN BE APPLIED TO ANY INSURANCE PLAN, ACCORDING TO TEXAS LAW, MYSELF OR MY LEGAL REPRESENTATIVE PRIOR TO TREATMENT WILL PAY ALL FEES.

Print name:_____

Or legal representative: _____

Signature:_____

Date:_____.