New Smyrna Wellness Center

502 Palmetto St, New Smyrna Beach, FL 32168

Phone: 386-957-1854 – Fax: 386-878-4967

Pre-Evaluation Patient Information Questionnaire

Personal Info:

Name: _____Date: _____/_____/_____

How did you hear about us? _____

Social Security:_____

Date of birth: _____/_____/_____ Age: _____ Height: _____ Weight: _____ Gender: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____ May we email you in the future: _____

What is your Facebook or Instagram?_____

Are you currently attending school? _____ Where?_____

Are you currently working? _____ What is your job? _____

How would you caterogorigize your work status?_____

Marital Status: _____

Do you have children? _ _____ How many children?_____

(If Female) Are you currently pregnant? _____

(If Female) Are you planning on gettting pregnant? _____

(If Female) Are you currently breast feeding? _____

Have you been arrested or charged with a crime in the past two years? _____

(If yes, please describe) _____

_____

Patient Signature: _____ Date: _____

New Smyrna Wellness Center

Are you currently on parole or probation? _____ (if yes, please see program coordinator)

Have you been evaluated for medical marijuana use by another physician in the past? _____

(If yes, please give name of practice, doctor, date seen and condition for evaluation) _____

_____

_____

Have you been denied a recommendation for medical marijuana use by another MD in the past? _____

(If yes, please explain) _____

_____

_____

Are you currently attending or have you attended any substance abuse or rehabilitation program? _____

(If yes, please provide details) _____

_____

Do you ever have thoughts of suicide or have you ever attempted suicide? _____

(If yes, please provide details) _____

_____

_____

Medical History:

Did you bring any medical records with you today? _____ (If yes, what is the synopsis?)_____

_____

_____

Do you have a primary care physician? _____ (if yes, please include their information below.)

Name: _____ Address: _____ Phone: _____

Have you talked to your primary care physician about medical marijuana? _____

Current medical complaint(s): _____

_____

_____

Patient Signature: _____ Date: _____

New Smyrna Wellness Center

What prescription drugs do you take currently and what dosages? _____

_____

_____

Do you currently use tobacco? _____ (If yes, how often?) _____

Do you currently use marijuana? _____ (If yes, how often and what methods?) _____

_____

_____

Do you currently drink alcohol? _____ (If yes, how much?) _____

_____

Do you currently use cocaine, methamphetamine, opiates, heroin or other street drugs? _____

(If yes, explain) _____

_____

Are you allergic to any medicine? _____ (If yes, list medicine) _____

_____

Have you ever been hospitalized? _____ (If yes, please provide dates and details) _____

_____

_____

Have you ever had surgery? _____ (If yes, please provide dates and details) _____

_____

_____

Please check any of the following problems anyone in your *immediate* family has:

- **Asthma** ◯
- **Stroke** ◯
- **High Blood Pressure** ◯
- **Cancer** ◯
- **Diabetes** ◯
- **Alcoholism** ◯
- **Hepatitis** ◯
- **Tuberculosis** ◯
- **Substance Abuse** ◯
- **Kidney Disease** ◯
- **Heart Disease** ◯
- **Sinusitis** ◯
- **Other _____**

Please check any of the following problems you have:

Sleeplessness	◯	**Palpitations**	◯
Chest Pain	◯	**Headaches**	◯
Constipation	◯	**Chronic pain**	◯
Nausea	◯	**Muscle Spasm**	◯
Diarrhea	◯	**Difficult swallowing**	◯
Loss of Appetite	◯	**Coughing**	◯
Stomach Pain	◯	**Fever**	◯
Depression	◯	**Heart Burn**	◯
Vomiting	◯	**Seizures**	◯
Anxiety	◯	**Eye**	◯
Rectal Pain	◯	**Problems**	◯
Swollen Ankles	◯	**Blood in Bowels**	◯
Skin Rash	◯	**Other** _____	

Patient Signature: _____ **Date:** _____

New Smyrna
Wellness Center

New Smyrna Wellness Center

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 _____ to have access to my medical records and speak to the New Smyrna Wellness on my behalf regarding my medical conditions.

I understand that I must be a Florida State resident to obtain an approval or recommendation for the use of Low-THC cannabis or medical cannabis under the Compassionate Medical Cannabis Act of 2014.

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 of 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 contaminates. I understand that the potential risks associated with an elevated daily consumption of medical marijuana includes risk with respect to the effect on my cardiovascular and pulmonary systems and psychomotor performance, risks associated with the long-term use of marijuana, as well as potential drug dependency. I am aware that the benefits and risks associated with the 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 of 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 may 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.

The Florida Office of Compassionate Use (HB 307 effective March 27, 2016) provides for the possession for the personal medical purposes of the patient with a physician approval or recommendation. It should be made clear that the physician, staff and representatives of this practice are not provided medical marijuana, nor are they encouraging any illegal activity in my obtaining medical marijuana.

New Smyrna Wellness Center

RELEASE OF LIABILITY, CONTINUED

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 possibility 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 Signature: _____ Date: _____

New Smyrna Wellness Center

Medical Marijuana Patient Declaration

I hereby declare that I have completely and truthfully disclosed all information regarding my medical condition and attest that I do not intent to use my medical recommendation for the purpose of illegally obtaining, growing or distributing medical marijuana. I attest that I am not a member, employee or agent of any media or law enforcement agency. It is illegal to film or record in this office with a video camera, cell phone, or any other recording devise be it a still image, video or audio. This is a direct violation of HIPPA regulations and patient/doctor confidentiality. I am aware that my recommendation can be revoked at any time and legal actions will be taken if I have perjured or misrepresented myself or my condition, my intentions or falsified any medical records to the physician. I also hereby authorize New Smyrna Wellness Center Centers, or its representative to discuss my condition for verification purposes only.

Additionally, I acknowledge the attending physician informed me of the nature of a recommended treatment, including but not limited to, any recommendation regarding medical marijuana. The risks, complications and expected benefits of any recommended treatment, including its likelihood of success and failure. I acknowledge the attending physician informed me of any alternatives to the recommended treatment, including the alternative of no treatment, and their risks and benefits. The physician may request that I visit another physician or specialist to further substantiate my condition. I will be informed of all the above mentioned regardless of whether or not I qualify as a patient.

Patient Name (Print): _____ Telephone Number: _____

Patient Signature: _____ Alt. Phone Number: _____

Current Address: _____ City: _____ State: _____ Zip: _____

The attending physician will fully explain to me the nature and purpose of medical marijuana treatment, including its benefits and possible side effects.

New Smyrna Wellness Center

HIPPA Notice of Privacy Practices Acknowledgement of Receipt

_____ By signing this, I hereby acknowledge that I have read and understand the privacy practice notice and may obtain copies upon my request. This acknowledgement will be filed with my records.

Authorization for Release of Confidential Records

I, _____, Date of Birth, _____, hereby authorize New Smyrna Wellness Center Centers to disclose and verify me as a patient to any law enforcement agency, my physician(s), Child Protective Services or any state approved Florida dispensary. This is valid during the period of time for which the recommendation has been issued. This consent is subject to written revocation only, at any time except to the extent that action has already been taken on the basis of this consent.

_____ I give permission for my medical records and file to be reviewed by another physician working with New Smyrna Wellness Center Centers. I understand that this might happen if the original doctor that evaluated me needs a secondary opinion, is not available, off premises, has moved or terminated his/her practice.

DO NOT SIGN BELOW THIS LINE

. . . . . .

I have asked the patient if he/she has any questions regarding his/her treatment with medical marijuana. I have answered those question to the best of my ability.

Physician's Signature: _____ Date: _____

New Smyrna Wellness Center

New Smyrna Wellness Center

Medical Marijuana Consent Form

A qualified physician may not delegate the responsibility of obtaining written informed consent to another person. The qualified patient or the patient's parent, or legal guardian if the patient is a minor, must initial each section of this consent form to indicate that the physician explained the information and, along with the qualified physician, must sign and date the informed consent form.

a. The Federal Government's classification of marijuana as a Schedule I controlled substance.

_____ The federal government has classified marijuana as a Schedule I controlled substance. Schedule I substances are defined, in part, as having (1) a high potential for abuse; (2) no currently accepted medical use in treatment in the United States; and (3) a lack of accepted safety for use under medical supervision. Federal law prohibits the manufacture, distribution and possession of marijuana even in states, such as Florida, which have modified their state laws to treat marijuana as a medicine.

_____ When in the possession or under the influence of medical marijuana, the patient or the patient's caregiver must have his or her medical marijuana use registration identification card in his or her possession at all times.

b. The approval and oversight status of marijuana by the Food and Drug Administration.

_____ 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, impurities, contaminates, and substances in addition to THC, which is the primary psychoactive chemical component of marijuana.

c. The potential for addiction.

_____ Some studies suggest that the use of marijuana by individuals may lead to a tolerance to, dependence on, or addiction to marijuana. I understand that if I require increasingly higher doses to achieve the same benefit or if I think that I may be developing a dependency on marijuana, I should contact Dr. Meredith or Trapani (name of qualified physician).

d. The potential effect that marijuana may have on a patient's coordination, motor skills, and cognition, including a warning against operating heavy machinery, operating a motor vehicle, or engaging in activities that require a person to be alert or respond quickly.

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64B15ER17-1 (64B15-14.013, F.A.C.)
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08/17

_____ The use of marijuana can affect coordination, motor skills and cognition. i.e., the ability to think, judge and reason. Driving under the influence of cannabis can double the risk of crashing, which escalates if alcohol is also influencing the driver. While using medical marijuana, I should not drive, operate heavy machinery or engage in any activities that require me to be alert and/or respond quickly and I should not participate in activities that may be dangerous to myself or others. I understand that if I drive while under the influence of marijuana, I can be arrested for "driving under the influence."

e. The potential side effects of medical marijuana use.

_____ Potential side effects from the use of marijuana include, but are not limited to, the following: dizziness, anxiety, confusion, sedation, low blood pressure, impairment of short term memory, euphoria, difficulty in completing complex tasks, suppression of the body's immune system, may affect the production of sex hormones that lead to adverse effects, inability to concentration, impaired motor skills, paranoia, psychotic symptoms, general apathy, depression and/or restlessness. Marijuana may exacerbate schizophrenia in persons predisposed to that disorder. In addition, the use of medical marijuana may cause me to talk or eat in excess, alter my perception of time and space and impair my judgment. Many medical authorities claim that use of medical marijuana, especially by persons younger than 25, can result in long-term problems with attention, memory, learning, drug abuse, and schizophrenia.

_____ I understand that using marijuana while consuming alcohol is not recommended. Additional side effects may become present when using both alcohol and marijuana.

_____ I agree to contact Dr. Meredith/Trapani if I experience any of the side effects listed above, or if I become depressed or psychotic, have suicidal thoughts, or experience crying spells. I will also contact Dr. Meredith/Trapani if I experience respiratory problems, changes in my normal sleeping patterns, extreme fatigue, increased irritability, or begin to withdraw from my family and/or friends.

f. The risks, 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 heart rhythms, numbness in the hands, feet, arms, or legs, anxiety attacks, and incapacitation. If I experience these symptoms, I agree to contact Dr. Meredith/Trapani immediately or go to the nearest emergency room.

_____ Numerous drugs are known to interact with marijuana and not all drug interactions are known. Some mixtures of medications can lead to serious and even fatal consequences. I agree to follow the directions of Dr. Meredith/Trapani regarding the use of prescription and non-prescription medication. I will advise any other of my treating physician(s) of my use of medical marijuana.

_____ Marijuana may increase the risk of bleeding, low blood pressure, elevated blood sugar, liver enzymes, and other bodily systems when taken with herbs and supplements. I agree to contact Dr. Trapani/Dr. Meredith immediately or go to the nearest emergency room if these symptoms occur.

_____ I understand that medical marijuana may have serious risks and may cause low birth weight or other abnormalities in babies. I will advise Dr. Trapani/Dr. Meredith if I become pregnant, try to get pregnant, or will be breastfeeding.

g. The current state of research on the efficacy of marijuana to treat the qualifying conditions set forth in this section.

_____ Cancer

- **There is insufficient evidence to support or refute the conclusion that cannabinoids are an effective treatment in cancers, including glioma.**

  There is evidence to suggest that cannabinoids (and the endocannabinoid system more generally) may play a role in the cancer regulation process. Due to a lack of recent, high quality reviews, a research gap exists concerning the effectiveness of cannabis or cannabinoids in treating cancer in general.

- **There is conclusive evidence that oral cannabinoids are effective antiemetics in the treatment of chemotherapy-induced nausea and vomiting.**

  There is insufficient evidence to support or refute the conclusion that cannabinoids are an effective treatment for cancer-associated anorexia-cachexia syndrome and anorexia nervosa.

_____ Epilepsy

- **There is insufficient evidence to support or refute the conclusion that cannabinoids are an effective treatment for epilepsy.**

  Recent systematic reviews were unable to identify any randomized controlled trials evaluating the efficacy of cannabinoids for the treatment of epilepsy. Currently available clinical data, therefore, consists solely of uncontrolled case series, which do not provide high-quality evidence of efficacy. Randomized trials of the efficacy of cannabinoids for different forms of epilepsy have been completed and await publication.

_____ Glaucoma

There is limited evidence that cannabinoids are an ineffective treatment in improving intraocular pressure associated with glaucoma. Lower intraocular pressure is a key target for glaucoma treatments. Non-randomized studies in healthy volunteers and glaucoma patients have shown short-term reductions in intraocular pressure with oral, topical eye drops, and intravenous cannabinoids, suggesting the potential for therapeutic benefit. A good-quality systematic review identified a single small trial that found no effect of two cannabinoids, given as an oromucosal spray, on intraocular pressure. The quality of evidence for the finding of no effect is limited, however, to be effective, treatments targeting lower intraocular pressure must provide continual rather than transient reductions in intraocular pressure. To date, those studies showing positive effects have shown only short-term benefit on intraocular pressure (hours), suggesting a limited potential for cannabinoids in the treatment of glaucoma.

_____ Positive status for human immunodeficiency virus

- **There is limited evidence that cannabis and oral cannabinoids are effective in increasing appetite and decreasing weight loss associated with HIV/AIDS.**

  There does not appear to be good-quality primary literature that reported on cannabis or cannabinoids as effective treatment for AIDS wasting syndrome.

_____ Acquired immune deficiency syndrome

- **There is limited evidence that cannabis and oral cannabinoids are effective in increasing appetite and decreasing weight loss associated with HIV/AIDS.**

  There does not appear to be good-quality primary literature that reported on cannabis or cannabinoids as effective treatments for AIDS wasting syndrome.

_____ Post-traumatic stress disorder

- **There is limited evidence (a single, small fair-quality trial) that nabilone is effective for improving symptoms of posttraumatic stress disorder.**

  A single, small crossover trial suggests potential benefit from the pharmaceutical cannabinoid nabilone. This limited evidence is most applicable to male veterans and contrasts with non-randomized studies showing limited evidence of a statistical association between cannabis use (plant derived form) and increased severity of posttraumatic stress disorder symptoms among individuals with posttraumatic stress disorder. There are other trials that are in the process of being conducted and if successfully completed, they will add substantially to the knowledge base.

_____ Amyotrophic lateral sclerosis

- **There is insufficient evidence that cannabinoids are an effective treatment for symptoms associated with amyotrophic lateral sclerosis.**

  Two small studies investigated the effect of dronabinol on symptoms associated with ALS. Although there were no differences from placebo in either trial, the sample sizes were small, the duration of the studies was short, and the dose of dronabinol may have been too small to ascertain any activity. The effect of cannabis was not investigated.

_____ Crohn's disease

- **There is insufficient evidence to support or refute the conclusion that dronabinol is an effective treatment for the symptoms of irritable bowel syndrome.**

  Some studies suggest that marijuana in the form of cannabidiol may be beneficial in the treatment of inflammatory bowel disease, including Crohn's disease.

_____ Parkinson's disease

- **There is insufficient evidence that cannabinoids are an effective treatment for the motor system symptoms associated with Parkinson's disease or the levodopa-induced dyskinesia.**

  Evidence suggests that the endocannabinoid system plays a meaningful role in certain neurodegenerative processes; thus, it may be useful to determine the efficacy of cannabinoids in treatment of the symptoms of neurodegenerative disease. Small trials of oral cannabinoid preparations have demonstrated no benefit compared to a placebo in ameliorating the side effects of Parkinson's disease. A seven-patient trial of nabilone suggested that it improved the dyskinesia associated with levodopa therapy, but the sample size limits the interpretation of the data. An observational study demonstrated improved outcomes, but the lack of a control group and the small sample size are limitations.

_____ Multiple sclerosis

- **There is substantial evidence that oral cannabinoids are an effective treatment for improving patient-reported multiple sclerosis spasticity symptoms, but limited evidence for an effect on clinician-measured spasticity.**

  Based on evidence from randomized controlled trials included in systematic reviews, an oral cannabis extract, nabiximols, and orally administered THC are probably effective for reducing patient-reported spasticity scores in patients with MS. The effect appears to be modest. These agents have not consistently demonstrated a benefit on clinician-measured spasticity indices.

_____ Medical conditions of same kind or class as or comparable to the above qualifying medical conditions.

- **The qualifying physician has provided the patient or the patient's caregiver a summary of the current research on the efficacy of marijuana to treat the patient's medical condition.**
- **The summary is attached to this informed consent as an Addendum _____**

_____ Terminal conditions diagnosed by a physician other than the qualified physician issuing the physician certification.

- **The qualifying physician has provided the patient or the patient's caregiver a summary of the current research on the efficacy of marijuana to treat the patient's terminal condition.**
- **The summary is attached to this informed consent as an Addendum _____.**

_____ Chronic nonmalignant pain

- **There is substantial evidence that cannabis is an effective treatment for chronic pain in adults.**

  The majority of studies on pain evaluated nabiximols outside the United States. Only a handful of studies have evaluated the use of cannabis in the United States, and all of them evaluated cannabis in flow form provided by the National institute of Drug Abuse. In contrast, many of the cannabis products that are sold in state-regulated markets bear little resemblance to the products that are available for research at the federal level in the United States. Pain patients also use topical forms.

h. That the patient's de-identified health information contained in the physician certification and medical marijuana use registry may be used for research purposes.

_____ The Department of Health submits a data set to The Medical Marijuana Research and Education Coalition for each patient registered in the medical marijuana use registry that includes the patient's qualifying medical condition and the daily dose amount and forms of marijuana certified for the patient.

_____ 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. Trapani/Dr. Meredith has informed me of the nature of a recommended treatment, including but not limited to, any recommendation regarding medical marijuana.

Dr. Trapani/Dr. Meredith also informed me of the risks, complications, and expected benefits of any recommended treatment, including the likelihood of success and failure. I acknowledge that Dr. Trapani/Dr. Meredith informed me of any alternatives to the recommended treatment, including the alternative of no treatment, and the risks and benefits.

Dr. Trapani/Dr. Meredith has explained the information in this consent form about the medical use of marijuana. I understand the information contained within this consent form.

Patient (print name) _____

Patient signature (or signature of the parent or legal guardian if the patient is a minor)

_____ Date _____

Qualified physician signature:

_____ Date _____

Witness:

_____ Date _____

64B8ER17-1 (64B8-9.018, F.A.C.)
64B15ER17-1 (64B15-14.013, F.A.C.)
DH-MOA-5026
08/17

Medical Marijuana Consent Form

A qualified physician may not delegate the responsibility of obtaining written informed consent to another person. The qualified patient, or the patient's parent or legal guardian if the patient is a minor, must initial each section of this consent form to indicate that the physician explained the information and, along with the qualified physician, must sign and date the informed consent form. This consent form contains three parts. Part A must be completed by all patients. Part B is only required for patients under the age of 18 with a diagnosed terminal condition who receive a certification for medical marijuana in a smokable form. Part C is the signature block and must be completed by all patients.

Part A: Must be completed for all medical marijuana patients

a. The Federal Government's classification of marijuana as a Schedule I controlled substance.

_____ The federal government has classified marijuana as a Schedule I controlled substance. Schedule I substances are defined, in part, as having (I) a high potential for abuse; (2) no currently accepted medical use in treatment in the United States; and (3) a lack of accepted safety for use under medical supervision. Federal law prohibits the manufacture, distribution and possession of marijuana even in states, such as Florida, which have modified their state laws to treat marijuana as a medicine.

____ When in the possession of medical marijuana, the patient or the patient's caregiver must have his or her medical marijuana use registry identification card in his or her possession at all times.

b. The approval and oversight status of marijuana by the Food and Drug Administration.

____ 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 federal oversight. Marijuana may contain unknown quantities of active ingredients, which may vary in potency, impurities, contaminants, and substances in addition to THC, which is the primary psychoactive chemical component of marijuana.

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Appointment Reminder Consent

I _____ authorize New Smyrna Wellness Center to contact me by automated SMS Text Message, Voice Messaging, or email for appointment reminders. I understand that message and data rates may apply

Please check your preferred contact method below & provide email or phone number:

☐ Email reminders and messaging

☐ SMS mobile text reminders and messaging

☐ Voice reminders and messaging

Phone Number:_____ Email:_____

I understand that text messages, voice messages and emails are not a secure format of communication. There is some risk that individually identifiable health information or other sensitive or confidential information contained in such text may be misdirected, disclosed or intercepted by unauthorized third parties.

Information included in the text messages, voice messages and emails may include your first name, date/time of appointments, name of provider, and office phone number or other pertinent information.

By signing below, I indicate I am the primary user for the mobile phone number listed above and accept the risks explained and consent to receive text messages, voice messages, and/or emails via automated technology from the New Smyrna Wellness Center to the phone number or email I have provided.

I may opt out of receiving these communications at any time by calling the office at (386) 957-1854. Please allow 2-3 days for processing.

By signing below, I am indicating that I have reviewed, acknowledged, and consent to the terms displayed above:

Signature of Patient/Responsible Party: _____ Date: _____

Printed Name of Patient/Responsible Party: _____ Date: _____

Name of Patient (If signed by other responsible party): _____