Michael Cheikin MD
Holistic Medicine & Physiatry
832 Germantown Pike, Suite 3
Plymouth Meeting, PA 19462
610-239-9901 cohlife.org

Medical Marijuana PATIENT Checklist

2/9/2021

	Date Complete	
Forms Received (6 pages including this checklist)		
Register on PA DOH MM Website*		
Take screenshot of Medical Marijuana registration page with registration number		
Make copy of driver's license or other proof of residency		
Complete pages 2-6 of Pack		
Send Total of 7 pages: Intake Pack (5 pages) Proof of Residency Screenshot of registration at PA COH		
Appointment with Dr Cheikin		
Apply for Card on PA DOH MM Website*		
After card received, visit dispensary*		

* Links and resources at cohlife.org/mm

Michael Cheikin MD
Holistic Medicine & Physiatry
832 Germantown Pike, Suite 3
Plymouth Meeting, PA 19462
610-239-9901 cohlife.org

Medical Marijuana Intake

Dear Patient: You can find additional information at: cohlife.org/medical-marijuana

Pennsylvania Patient ID: _____
First Name _____
Last Name _____
Date of Birth _____
Gender _____
Street Address Apt/Unit#_____
City PA Zip Code _____
Contact Phone _____
Email _____
Emergency Contact Name _____
Emergency Contact Phone _____

Are you currently using any controlled substances?
Yes No
If yes, please list: _____
Prescribing Physician(s) _____

Circle if you have or have had any of the following?

Abdominal Problems
Arthritis
Asthma
Diabetes
Dizziness/Balance Issues
Fainting Spells
Falls
Headaches
Heart Disease
High Blood Pressure
Lung Disease
Muscle Cramps
Seizures

Please circle the medical condition(s) that you would like to review today:	**How long?**	**PLEASE LEAVE BLANK**
Amyotrophic lateral sclerosis		
Anxiety disorders		
Autism		
Cancer, including remission therapy		
Crohn's disease		
Damage to the nervous tissue of the central nervous system (brain-spinal cord) with objective neurological indication of intractable spasticity, and other associated neuropathies		
Dyskinetic and spastic movement disorders		
Epilepsy		
Glaucoma		
HIV/AIDS		
Huntington's disease		
Intractable seizures		
Multiple sclerosis		
Neurodegenerative Diseases		
Neuropathies		
Opioid use disorder for which conventional therapeutic interventions are contraindicated or ineffective, or for which adjunctive therapy is indicated in combination with primary therapeutic interventions		
Parkinson's disease		
Post-traumatic stress disorder		
Severe chronic or intractable pain of neuropathic origin or severe chronic or intractable pain		
Sickle cell anemia		
Terminal illness		
Tourette syndrome		

Michael Cheikin MD
Holistic Medicine & Physiatry
832 Germantown Pike, Suite 3
Plymouth Meeting, PA 19462
610-239-9901 cohlife.org

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. I authorize Medical Certification PC to converse, electronically submit, and release information of my medical condition.

I understand that I must be a Pennsylvania resident to obtain an approval or recommendation for the use of medical cannabis. 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 in 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 contaminants. I understand the potential risks associated with an elevated daily consumption of medical marijuana including risks 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 for 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 might 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.

Pennsylvania's Medical Marijuana Act – Senate Bill 3, approved April 12, 2016 – provides for the possession of medical marijuana for the personal medical purposed 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 providing medical marijuana, nor are they encouraging any illegal activity in my obtaining medical marijuana.

I, the undersigned, hereby request a consultation by the physician for purposes of determining the appropriateness of medical marijuana treatment. 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 medical 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 possible continuance of cannabis use beyond the term of the approval.

Furthermore, the undersigned, or anyone acting on my behalf, holds PA Green Medical, Medical Certification PC, the physician and his/her principals, agents and employees, free of and harmless from any liability resulting from my release, a data breach and my use of medical marijuana. I further understand that by signing below, I am authorizing the release of any part of this record.

Patient Name (Print)_____

Patient Signature _____Date_____

Michael Cheikin MD
Holistic Medicine & Physiatry
832 Germantown Pike, Suite 3
Plymouth Meeting, PA 19462
610-239-9901 cohlife.org

Acknowledgements, Agreements, Disclosures and Informed Consent

I, _____, understand that medical marijuana is a medicine used in treating the suffering caused by serious and debilitating medical conditions.

I have been advised that the use of medical marijuana may affect my coordination, motor skills and cognition and ways that could impair my ability to drive and agree not to operate heavy machinery, drive or engage in potentially hazardous activities.

I understand that side effects may occur while I am taking medical marijuana. Side effects of medical marijuana may include but are not limited to: euphoria, difficulty in completing complex tasks, low blood pressure, sedation, dysphoria, alterations in the perception of time and space, dizziness, anxiety, confusion, impairment to short term memory, inability to concentrate, suppression of the bodies immune system, increased talkativeness, impairment of motor skills, delayed reaction time, lack of physical coordination, paranoia, and increase eating.

I understand that some patients may become dependent on marijuana. This means they experience withdrawal symptoms when they stop using marijuana. Signs of withdrawal symptoms may include: feelings of depression, sadness, irritability, insomnia, restlessness, agitation, loss of appetite, trouble concentrating, sleep disturbances and unusual tiredness.

I understand the chronic use of medical marijuana may lead to laryngitis, bronchitis and general apathy. I understand that although marijuana does not produce a specific psychoses, it may exacerbate schizophrenia and persons predispose to that disorder.

I agree to tell the attending physician if I have ever had symptoms of depression, been psychotic, attempted suicide or had any other mental problems. I also agree to tell the attending physician if I have ever been prescribed or taking medicine for any of the conditions stated above. Furthermore, I understand that the attending physician does not suggest nor condone that I cease treatment and or medication that stabilize my mental or physical condition.

I understand there are a few known interactions between marijuana and medications other than herbs.

However, very few interactions between herbs and medications have been studied. I agree to tell my attending physician if I am using any herbs, supplements or other medications. I am aware that a Notice of Compliance has not been issued under the Food and Drug Regulations concerning the safety and effectiveness of marijuana as a 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 illegal under federal law.

I understand some users might develop a tolerance to marijuana. This means higher and higher doses are required to achieve the same benefit. It is recommended for patients to have an intermission with the drug for at least 3 weeks every 3 to 4 months. If I think I may be developing a tolerance for marijuana, I will notify the attending physician. I understand 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. I accept such risk.

I understand should respiratory problems or other ill effects be experienced in association with the use of medical marijuana, I agree to discontinue it's use and report any such problems or effects to the attending physician.
Although smoking marijuana has not been linked to lung cancer, smoking marijuana 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 in the lungs, mouth and tongue. I have been advised that medical marijuana smoke contain intake that substantially reduce the harmful effects of smoking such as vaporizers, and oils etc.

Michael Cheikin MD
Holistic Medicine & Physiatry
832 Germantown Pike, Suite 3
Plymouth Meeting, PA 19462
610-239-9901 cohlife.org

I understand marijuana varies in potency. The effects of marijuana may also very with the delivery method. Estimating the proper marijuana dosage is very important. Symptoms of marijuana overdose include, but are not limited to nausea, vomiting, hacking cough, heart rhythm disturbances, numbness in the limbs, anxiety attacks and incapacitation.

If I start taking medical marijuana, I agree to tell my attending physician if I: start to feel sad or have crying spells, lose interest in my normal activities, have changes in my normal sleeping patterns, become more irritable than usual, lose my appetite, become unusually tired, withdraw from family and friends, or any other side effect that is not to my liking.

I agree that if I am a female patient that I will contact my attending physician if I become or are thinking about becoming pregnant. I acknowledge that the use of medical marijuana creates pass-through problems to a fetus during pregnancy into a baby during breast-feeding.

I understand that using marijuana while under the influence of alcohol is not recommended. Additional side effects may become present when using both alcohol and marijuana. I understand that I should not be driving a vehicle while using marijuana and that I can get a DUI for driving under the influence.

Medical marijuana is not regulated by that US FDA and therefore may contain unknown quantities of active ingredients, impurities and or contaminants.

I am not permitted to smoke within 1000 feet of any daycare or school. If I reside near those institutions, I must use my medicine within the privacy of my own home.

I agreed to follow up with the attending physician at PA Green Medical/Medical Certification PC with supporting medical records pertaining to my medical conditions.

I understand the attending physician, staff and or representatives of PA Green Medical/Medical Certification PC are neither providing, dispensing nor encouraging me to obtain medical marijuana.

I certify that I've been read this document and declare under penalty of perjury that the information contained herein is true, correct and complete. I acknowledge that any manipulation, alteration or falsification of this form, will result in the immediate termination of the letter of recommendation and of any legal right to my use of medical marijuana. Furthermore, the above-mentioned activities will be reported to the appropriate local authorities.

The physician, staff and representatives of PA Green Medical/Medical Certification PC are addressing specific aspects of my medical care and, unless otherwise stated, are in no way establishing themselves as my primary care physician/provider. Furthermore, the undersigned, my heirs, assigns, or anyone else acting on my behalf, hold PA Green Medical, Medical Certification PC, the physician, his/her principals, agents and employees, free of and harmless from any responsibility for any harm resulting to me and/or other individuals as a result of my medical marijuana use.

Patient Signature _____Date_____

Michael Cheikin
832 Germantown Pike, Suite 3
Plymouth Meeting, PA 19462
610-239-9901 cohlife.org

Credit Card Authorization

I,_____ authorize Michael Cheikin M.D. to charge my credit card for $175.00 for the Medical Marijuana Evaluation.

I understand that the charge will appear as “Wyndmoor Rehabilitation Associates, P.C.”

I agree that if I challenge any fees with my credit card company, I will be responsible for any and all legal fees and associated costs required by Michael Cheikin to defend such a challenge.

_____
PRINT NAME as it appears on credit card

_____
Signature/Date

MC/VISA Account No. _____

Expiration Date: _____

3 Digit Code: _____

Billing Address: _____

_____

_____