PATIENT INFORMATION

(TO BE COMPLETED BY PATIENT)

DATE:_____

_____ □ MALE □ FEMALE

LAST NAME **FIRST NAME** **MIDDLE INITIAL**

_____/_____/_____ _____ _____ _____/_____/_____

DATE OF BIRTH **AGE** **RACE/ETHNICITY** **SOCIAL SECURITY NUMBER**

_____ (_____)_____

EMAIL ADDRESS **PREFERRED PHONE NUMBER**

OK TO SEND MEDICAL INFORMATION VIA EMAIL? □ YES □ NO **OK TO CONTACT/LEAVE MESSAGE? □ YES □ NO**

_____ (_____)_____

OCCUPATION **ALTERNATIVE PHONE NUMBER**

OK TO CONTACT/LEAVE MESSAGE? □ YES □ NO

_____

STREET ADDRESS **CITY** **STATE** **ZIP CODE**

DO YOU HAVE A CAREGIVER? □ YES □ NO NAME:_____ **CONTACT NUMBER:**_____

EMERGENCY CONTACT (OUTSIDE OF HOME): _____**CONTACT NUMBER:**_____

RELATIONSHIP TO PATIENT:_____

SOCIAL HISTORY

□ **ALCOHOL ABUSE** □ **SUBSTANCE ABUSE:**_____ □ **MENTAL ILLNESS:**_____

□ **EATING DISORDER:**_____ □ **SERIOUS ILLNESS:**_____

NOTES:

FAMILY HISTORY

MOTHER	FATHER
□ ALCOHOL ABUSE	□ ALCOHOL ABUSE
□ SUBSTANCE ABUSE _____	□ SUBSTANCE ABUSE _____
□ EATING DISORDER _____	□ EATING DISORDER _____
□ MENTAL ILLNESS _____	□ MENTAL ILLNESS _____
□ SERIOUS ILLNESS _____	□ SERIOUS ILLNESS _____

NOTES:

PATIENT INFORMATION

(TO BE COMPLETED BY PATIENT)

PATIENT NAME:_____**AGE**_____**DATE:**_____

PAST MEDICAL HISTORY – MARK ALL THAT APPLY

- ☐ ALS (LOU GEHRIG'S)
- ☐ ANOREXIA
- ☐ ANXIETY
- ☐ ARTHRITIS
  - RHEUMATOID
  - NON-RHEUMATOID
- ☐ BACK PAIN
- ☐ CAHCEXIA
- ☐ CARDIOVASCULAR DISEASE
- ☐ CANCER
- ☐ CHROMIC ABDOMINAL PAIN
- ☐ CROHN'S DISEASE
- ☐ DEPRESSION
- ☐ DIABETES
- ☐ EPILEPSY/SEIZURES
- ☐ FREQUENT NAUSEA/VOMITING
- ☐ GLAUCOMA
- ☐ HEPATITIS C
- ☐ HIGH BLOOD PRESSURE/HYPERTENSION
- ☐ HIGH CHOLESTEROL
- ☐ HIV/AIDS
- ☐ INFECTIOUS DISEASE
- ☐ IRRITABLE BOWEL SYNDROME (IBS)
- ☐ KIDNEY DISEASE
- ☐ LIVER DISEASE
- ☐ LUNG DISEASE
- ☐ LYME DISEASE
- ☐ MENOPAUSE
- ☐ MIGRAINES
- ☐ MUSCLE SPASMS
- ☐ MUSCULAR DYSTROPHY
- ☐ MULTIPLE SCLEROSIS
- ☐ NEUROLOGICAL DISORDER
- ☐ OBESITY
- ☐ PAIN – SEVERE/CHRONIC
- ☐ PARKINSON'S DISEASE
- ☐ PTSD
- ☐ SICKLE CELL ANEMIA
- ☐ SKIN DISORDERS
- ☐ SPASTICITY
- ☐ STROKE – WHEN?_____
- ☐ OTHER:_____

DESCRIBE SYMPTOMS:

_____

_____

_____

SEVERITY: ☐ MILD ☐ MODERATE ☐ SEVERE

HOW EFFECTIVE WERE PRIOR TREATMENTS FOR YOUR CONDITION(S)? ☐ VERY EFFECTIVE ☐ EFFECTIVE ☐ SOMEWHAT EFFECTIVE ☐ N/A

SURGICAL HISTORY

_____

_____

_____

_____

ARE YOU RECIEVEING CARE FROM A PRIMARY CARE PHYSICIAN OR SPECIALIST PHYSICIAN? ☐ YES ☐ NO

LAST VISIT:_____

PHYSICIAN NAME:_____

PHYSICIAN LOCATION:

_____

PATIENT INFORMATION

(TO BE COMPLETED BY PATIENT)

PATIENT NAME:____**AGE**________**DATE:**__________________________

ALLERGIES (MEDICATIONS, PRODUCTS AND/OR FOODS)

____

____

____

____

MEDICATIONS

MEDICATION/ DOSAGE	PER DAY	REASON
		☐ CHRONIC PAIN ☐ NEUROPATHY ☐ ANXIETY/DEPRESSION OTHER:____________________
		☐ CHRONIC PAIN ☐ NEUROPATHY ☐ ANXIETY/DEPRESSION OTHER:____________________
		☐ CHRONIC PAIN ☐ NEUROPATHY ☐ ANXIETY/DEPRESSION OTHER:____________________
		☐ CHRONIC PAIN ☐ NEUROPATHY ☐ ANXIETY/DEPRESSION OTHER:____________________
		☐ CHRONIC PAIN ☐ NEUROPATHY ☐ ANXIETY/DEPRESSION OTHER:____________________
		☐ CHRONIC PAIN ☐ NEUROPATHY ☐ ANXIETY/DEPRESSION OTHER:____________________
		☐ CHRONIC PAIN ☐ NEUROPATHY ☐ ANXIETY/DEPRESSION OTHER:____________________
		☐ CHRONIC PAIN ☐ NEUROPATHY ☐ ANXIETY/DEPRESSION OTHER:____________________
		☐ CHRONIC PAIN ☐ NEUROPATHY ☐ ANXIETY/DEPRESSION OTHER:____________________
		☐ CHRONIC PAIN ☐ NEUROPATHY ☐ ANXIETY/DEPRESSION OTHER:____________________
		☐ CHRONIC PAIN ☐ NEUROPATHY ☐ ANXIETY/DEPRESSION OTHER:____________________

PATIENT INFORMATION

(TO BE COMPLETED BY PATIENT)

PATIENT NAME:_____**AGE**_____**DATE:**_____

CANNABIS HISTORY

HOW EFFECTIVE IS THE USE OF CANNABIS FOR YOUR CONDITION? ☐ VERY EFFECTIVE ☐ EFFECTIVE ☐ SOMEWHAT EFFECTIVE ☐ N/A

HAVE YOU EVER HAD AN ADVERSE REACTION TO CANNABIS? ☐ YES ☐ NO ☐ N/A

HAVE YOU EVER OR DO YOU HAVE A MEDICAL CANNABIS RECOMMENDATION? ☐ NEVER ☐ PREVIOUSLY ☐ CURRENTLY

IF PREVIOUSLY/CURRENTLY, BY WHOM?
PHYSICIAN NAME_____ **(**_____**)**_____

PATIENTS ARE ONLY ALLOWED ONE CERTIFIED PROVIDER TO UPDATE YOUR COMPASSIONATE USE REGISTRY. WOULD YOU LIKE OUR STAFF TO REQUEST DEACTIVATION OF YOUR PREVIOUS/CURRENT REGISTRY WITH THE PHYSICIAN LISTED ABOVE? ☐ YES ☐ NO

TETRA HEALTH CARE WILL BE YOUR CERTIFIED PROVIDER FOR COMPASSIONATE USE LOW-THC/MEDICAL CANNABIS BUT WILL NOT ASSUME RESPONSIBILITY FOR ANY OTHER MEDICAL NEEDS.

TETRA HEALTH CARE DOES NOT ACCEPT INSURANCE AND WILL NOT BILL FOR SERVICES.

_____ ___/___/_____

PATIENT SIGNATURE DATE

_____ ___/___/_____

DOCTOR SIGNATURE DATE

NOTICE OF PRIVACY PRACTICES

(TO BE READ AND SIGNED BY PATIENT)

This Notice describes how medical information about you may be used and/or disclosed, and how you can access your healthcare information

PLEASE REVIEW THIS NOTICE CAREFULLY

Tetra Health Care is committed to maintaining the privacy of your protected health information (PHI), which includes information about your health condition and the care and treatment you receive from this office. The creation of a record detailing the care and services you receive helps this office to provide you with high quality care. This Notice also details your rights regarding your PHI.

Without consent required, Tetra Health Care may use and/or disclose your PHI for the purposes of:

- TREATMENT: In order to provide you with the health care you require this office will provide your PHI to those health care professionals, whether with Tetra Health Care or not, directly involved in your care so that they may understand your health conditions and needs. For example, a physician treating you for a condition or disease may need to know the results of your latest physician examination by this office. Also, your Tetra Health Care provider may register as your ordering physician with the State of Florida Compassionate Use Registry.
- PAYMENT: In order to receive payment for services provided to you, this office may provide your PHI, directly or through a billing service, to appropriate third party payors, pursuant to their billing and payment requirements.
- HEALTHCARE OPERATIONS: Tetra Health Care may use and disclose PHI for healthcare operations. These uses and disclosures are necessary to operate Tetra Health Care and to make sure that office patients receive appropriate care. For example, this office may use medical information to review treatments and services and to evaluate the performance of providers and the care provided patients.
- AS REQUIRED BY LAW: Tetra Health Care will disclose PHI when required to do so by federal, state or local law.

Other Permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law. Without your authorization, this office is expressly prohibited to use or disclose your PHI for marketing purposes. Tetra Health Care may not sell your PHI without your authorization. You may revoke this authorization, at any time, in writing except to the extent that this office has taken an action in reliance on the authorization.

Your rights with respect to your PHI:

- You have the right to inspect and copy your PHI. Under federal law, however, you may not inspect or copy the following records: information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.
- You have the right to request a restriction of your PHI. This means that you may ask Tetra Health Care not to use or disclose any part of your PHI for the purposes of treatment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must be in writing and state the specific restriction requested and to whom you want the

- restriction to apply. Tetra Health Care is not required to agree to a restriction that you may request. If your Tetra Health Care physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another service provider.
- You have the right to request to receive confidential communications from this office by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from Tetra Health Care, upon request, even if you agreed to accept this notice alternatively, e.g., electronically.
- You have the right to request an amendment to your PHI. If Tetra Health Care denies your request for amendment, you have the right to file a statement of disagreement and Tetra Health Care may prepare a rebuttal.
- You have the right to receive an accounting of certain disclosures this office has made, if any, of your PHI.

Tetra Health Care reserves the right to change this notice and to make the changed notice effective for medical information we already have about you as well as any information we receive in the future. You are entitled to a copy of the notice currently in effect. Tetra Health Care will inform you of any significant changes to this notice. You then have the right to object or withdraw as provided in this notice.

Breach of PHI:

- Tetra Health Care will notify you if a reportable breach is discovered. Notification will be made to you no later than 60 days from the breach discovery and will include a brief description of how the breach occurred, the PHI involved and contact information for you to ask questions.

Complaints:

- Complaints about this Notice or how Tetra Health Care handles your PHI should be directed to the Tetra Health Care HIPAA Compliance Officer. If you are not satisfied with the manner
- This notice was originally published and effective on February 1, 2017. in which a complaint is handled you may submit a formal complaint to the Department of Health and Human Services, Office for Civil Rights. Tetra Health Care will not retaliate against you for filing a complaint.
- Tetra Health Care is required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to PHI and to notify affected individuals following a breach of unsecured protected health information. If you have any questions about this Notice, please ask to speak with the HIPAA Compliance Officer.

Signature below is acknowledgement that you have received or been given opportunity to receive this Notice of Privacy Practices:

Printed Name:_____

Signature:_____ DATE:_____/_____/_____

CONSENT TO TREATMENT

(TO BE READ AND SIGNED BY PATIENT)

I hereby authorize Tetra Health Care and its personnel (hereby referred to as the "Provider's Personnel") to examine and evaluate my medical condition and, based on the findings of that examination and evaluation, to:

- Determine that I qualify for the use of low-THC or medical cannabis, order my use of low-THC or medical cannabis, and add my name to the compassionate use registry;

  And/or

- Certify that I qualify for the medical use of marijuana.

I understand that as part of my examination, evaluation and ongoing treatment, I may be expected to give blood, urine and possibly other bodily specimen for testing by a licensed clinical laboratory; and I hereby authorize the Provider's Personnel to collect those specimens from me, to submit them for testing, and to obtain the results.

The Provider's Personnel presented me with this written Consent to Treatment after meeting with me, and explaining:

- The therapies and treatments that will be provided to me;
- That the therapies and treatments appear to be indicated by the results of my examination and evaluation;
- The substantial risks and hazards associated with each such therapy and treatment, specifically including the potential benefits versus the potential risks of using low-THC cannabis, medical cannabis, and marijuana;
- The medically acceptable alternatives to each therapy and treatment, if and to the extent acceptable alternatives exist.
- That there is a lack of scientific data regarding the potential danger of long term use of low-THC cannabis, medical cannabis, or marijuana;
- That there is no guarantee with respect to the benefits that I may or may not realize from the therapies and treatments referred to above; and
- That the possession and use of marijuana violates Federal Law.

I have read this Consent to Treatment, and have had the opportunity to have all of my questions answered by the Provider's Personnel with respect to the treatments and therapies referred to above. I fully understand this form and am signing it voluntarily.

PATIENT:	WITNESS:
_____	_____
Signature	Signature
_____	_____
Print Name	Print Name
_____	_____
Date	Date

Tetra Health Care requires women and teen girls to have a urine pregnancy test before meeting with a doctor to discuss whether medical marijuana is an option for them. This routine test is done on everyone of childbearing age, even if you are not sexually active. If there is a chance you could be pregnant, please let the Medical Assistant or physician know.

- I, _____, consent to having a pregnancy test done today.

  _____ _____

  (PATIENT SIGNATURE) (DATE)

- I, _____, decline having a pregnancy test.

  _____ _____

  (PATIENT SIGNATURE) (DATE)

  REASON:_____

Pregnancy Test hCG Urine Test Give □ Yes □ No

Pregnancy Test Result _____

Technician's Signature: _____ Date: _____

Authorization for the Use and Disclosure of Protected Health Information

Patient Name	Date of Birth
Last 4 digits of Patient Social Security Number	Patient Phone Number

Street Address Apt. # City State Zip Code

By signing this form, I understand that I am authorizing the designated medical records custodians or database custodian to use and/or disclose my protected health information (PHI) as defined under 45 CFR 164.501, the federal regulations implementing the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as described below to the following person(s) or organization(s):

Obtain From:	Release To:
Name	Name
Street Address	Street Address
City, State, Zip Code	City, State, Zip Code
Fax Number:	Fax Number:
Phone Number:	Phone Number:

Purpose of Requesting Records: _____

I specifically authorize the use and disclosure of the following PHI: **Initial areas selected and provide specifics if applicable.**

_____ Medical records released from above to TETRA _____

_____ Last office visit note _____

_____ Labs or Pathology _____

_____ Other information requested _____

_____ ALL medical records in the custody of TETRA released to above _____ _____

I further authorize the release of records regarding:

A. _____ Mental/Emotional Health **B. _____ Substance Abuse** **C._____ HIV/AIDS**

D. _____ Genetic Information **E. _____ Records created by non-TETRA providers**

I understand that I may be charged a reasonable fee for copying patient records and payment is expected when the copies are received from TETRA **If requesting information relating to: 1) Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection; 2) treatment for drug or alcohol abuse; 3) mental or emotional health or psychiatric care, excluding psychotherapy notes or 4) genetic testing, specific authorization on this form or a court order is required since this information is privileged. A separate authorization is required for psychotherapy session notes. Psychotherapy session notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. 45 CFR 164.501.**

I may revoke this authorization at any time by notifying TETRA of my intent to revoke this authorization. Returning a copy of this form, signed and dated with the word "revoked" is sufficient notice. However, I understand that such revocation will not have any effect on any information already used or disclosed by TETRA in reliance on the release obtained prior to revocation. This authorization form expires one year from signature or on _____. I understand that PHI released to a third party pursuant to this form may be re-disclosed and may no longer be protected by state and federal law. I may inspect and receive a copy of the information to be used and disclosed pursuant to this Authorization form. I understand that I am not required to sign this Authorization form in exchange for receiving treatment from TETRA. I understand that I may refuse to sign this form.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Printed name of Patient or Personal Representative Relationship to patient if Personal Representative

HISTORY AND PHYSICAL

PATIENT NAME:_____**AGE**_____**DATE:**_____

CHIEF COMPLAINT

REVIEW OF SYSTEMS – TO BE COMPLETED BY TETRA HEALTH CARE

REVIEWED PATIENT INFORMATION FORM: ☐ YES ☐ NO

	POS	NEG	NOTES
FEVER	☐	☐	
WEIGHT LOSS	☐	☐	
CHRONIC PAIN	☐	☐	
HEENT	☐	☐	
CARDIOVASCULAR	☐	☐	
GASTROINTESTINAL	☐	☐	
GENITOURINARY	☐	☐	
MUSCULOSKELETAL	☐	☐	
NEUROLOGIC/PSYCHIATRIC	☐	☐	
SLEEP DISORDER	☐	☐	
CANCER	☐	☐	
SEIZURES	☐	☐	
OTHER	☐	☐	

HISTORY AND PHYSICAL

PATIENT NAME:_____**AGE**_____**DATE:**_____

BP:_____/_____ **PULSE:**_____ **HEIGHT:**_____ '_____ **WEIGHT:**_____**LBS. TEMP:**_____**°F**

GENERAL APPEARANCE: ☐ WNL ☐ NAD ☐ AAO x 4
ABNORMALITIES:_____

NOTE ALL ABNORMALITIES:
SKIN & LYMPH NODES ☐ NORMAL ☐ SCARS/LESIONS/RASHES ☐ LYMPHODENOPATHY
NOTES:_____

HEAD & NECK ☐ NORMAL ☐ NC,AT ☐ PERRLA/EOMI ☐ NARES PATENT ☐ ORAL MOIST MUCOSA
NOTES:_____

LUNGS ☐ CTA W/O WHEEZES
NOTES:_____

HEART ☐ RRR W/O MURMUR
NOTES:_____

ABDOMEN ☐ NORMAL
NOTES:_____

EXTREMITIES ☐ NORMAL
NOTES:_____

NEUROLOGICAL ☐ TTP IN C-SPINE ☐ TTP IN L-SPINE ☐ LIMITED ROM ☐ MUSCLE SPASMS
NOTES:_____

OTHER PERTINENT FINDINGS:_____
_____
_____
_____

ASSESSMENT RELATIVE TO LOW-THC/MEDICAL CANNABIS USE:
_____
_____
_____
_____
_____

TREATMENT PLAN:
_____
_____
_____
_____
_____

HISTORY AND PHYSICAL

PATIENT NAME:_____**AGE**_____**DATE:**_____

LOW-THC/MEDCIAL CANNABIS RECOMMENDED: ☐ YES ☐ NO

DOSE:_____ DURATION:_____

ROUTE: ☐ PO ☐ TOPICAL ☐ INHALED ☐ OTHER:_____

FOLLOW-UP: 90-DAY TREATMENT PLAN
☐ TELEPHONIC ☐ IN-PERSON ☐ VIDEO

I CERTIFY THAT THIS PATIENT'S CONDITION(S) MEET(S) THE CRITERIA SET FORTH BY FLORIDA AMENDMENT 2 FOR THE USE OF LOW-THC/MEDICAL CANNABIS. I HAVE DISCUSSED THE RISKS, BENEFITS AND SIDE EFFECTS OF LOW-THC/MEDICAL CANNABIS WITH THIS PATIENT. I HAVE INFORMED THE PATIENT OF HOW THE CURRENT FLORIDA LAW WORKS IN REGARDS TO A TREATMENT PLAN. THE PATIENT-DOCTOR RELATIONSHIP BEGINS TODAY AND THE PATIENT'S ORDER WILL BE PROCESSED IN THE FLORIDA COMPASSIONATE USE REGISTRY AT THE 90-DAY MARK.

I HAVE EVALUATED THIS PATIENT ON_____/_____/_____AT_____AM/PM AND THE RISKS OF TREATING WITH LOW-THC/MEDICAL CANNABIS ARE REASONABLE IN LIGHT OF POTENTIAL BENEFIT.

COMPASSIONATE USE REGISTRY COMPLETED:_____/_____/_____

REGISTRY ID:_____

PHYSICIAN NAME/SIGNATURE:_____/_____

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 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 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.

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. _____ (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.

_____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 concentrate, 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. _____ 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. _____ 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.

g. 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. _____ 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. _____ 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. _____ 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 birthweight or other abnormalities in babies. I will advise Dr. _____ if I become pregnant, try to get pregnant, or will be breastfeeding.

h. 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 for cancers, including glioma.

  There is evidence to suggest that cannabinoids (and the endocannabinoid system more generally) may play a role in the cancer regulation processes. 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 consist solely of uncontrolled case series, which do not provide high-quality evidence of efficacy. Randomized trials of the efficacy of cannabidiol for different forms of epilepsy have been completed and await publication.

____ **Glaucoma**

- There is limited evidence that cannabinoids are an ineffective treatment for 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 systemic 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 treatments 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 forms) 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 diseases, 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 treating the symptoms of neurodegenerative diseases. 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 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 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 flower form provided by the National Institute on 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.

  While the use of cannabis for the treatment of pain is supported by well-controlled clinical trials, very little is known about the efficacy, dose, routes of administration, or side effects of commonly used and commercially available cannabis products in the United States.

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

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

Dr. _____ has explained the information in this consent form about the medical use of marijuana.

Patient (print name) _____

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

_____ Date _____

I have explained the information in this consent form about the medical use of marijuana to _____ (Print patient name).

Qualified physician signature:

_____ Date _____

Witness:

_____ Date _____