Medical Marijuana Consent

Center for Holistic Medicine

Patient Name: ________________________________ Patient DOB: __________

Date of Certification Evaluation: ______________________________________

Confirmation number: ____

I am being evaluated for a physician's recommendation for the use of medical marijuana. The physician will make this recommendation based, in part, on the medical information I have provided. I have not misrepresented my medical condition in order to obtain this recommendation and it is my intent to use marijuana only as needed for the treatment of my medical condition, not for recreational or non-medical purposes. I understand that it is my responsibility to be informed regarding state and federal laws regarding the possession, use, sale/purchase and or distribution of marijuana. I have been informed of and understand the following: (Please initial each item below)

A qualified physician may not delegate the responsibility of obtaining written informed consent to another person. The qualified patient o r 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.

Benefits:

____________Most of the benefits of medical marijuana are based on the positive experiences of patients. Evidence from research suggests that marijuana may be an effective treatment for chronic pain, nerve pain, and muscle spasms. Marijuana can reduce nausea and vomiting (Especially in patients receiving cancer chemotherapy), improve sleep and can increase appetite.

Risks and pertinent medicolegal acknowledgements:

1._________ The federal government has classified marijuana as a Schedule I controlled substance. Schedule I substances are defined, in part, as having (1) 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 Pennsylvania, which have modified their state laws to treat marijuana as medicine.

2.________ 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 standards, quality control, or other oversight. Marijuana may contain unknown quantities of active ingredients (i.e., Can vary in potency), impurities, contaminants, and substances in addition to THC, which is the primary psychoactive chemical component of marijuana.

3. ________ The use of marijuana can affect coordination, motor skills and cognition, i.e., the ability to think, judge and reason. While using marijuana, I should not drive, operate heavy machinery or engage in any activities that require me to be alert and/or respond quickly. 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."

4. ________ 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, inability to concentrate, impaired motor skills, paranoia, psychotic symptoms, general apathy, depression and or restlessness. Medical marijuana may affect the production of sex hormones. 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 judgement. Many medical authorities claim that use of cannabis, especially by persons younger than 25 can result in long term problems with attention, memory, learning, a tendency to drug abuse and schizophrenia. Dr. Ferraro recommends cannabis use only for the relief of serious symptoms, and not for habitual use.

5. ________ 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. Cannabis should be treated as an open container of alcohol. It should not be within reach in the car and should not be extinguished in the vehicles ash tray.

6. _________I agree to contact Dr. Ferraro 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. Ferraro 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.

7. ________ Smoking marijuana may cause respiratory problems and harm, including bronchitis, emphysema and laryngitis. In the opinion of many researchers, marijuana smoke contains known carcinogens (chemicals that can cause cancer) and smoking marijuana may increase the risk of respiratory diseases and cancer in the lung, mouth and tongue. In addition, marijuana smoke contains harmful chemicals known as tars. If I begin to experience respiratory problems when using marijuana, I will stop using it and report my symptoms to a physician.

8. _________The risks, benefits and drug interactions of marijuana are not fully understood. If I am taking medications or undergoing treatment for any medical condition, I understand that I should consult with my treating physician(s) before using marijuana and that I should not discontinue any medication or treatment previously prescribed unless advised to do so by the treating physician(s). 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 discuss medical marijuana treatment with all of my treating physicians to decrease risk of these consequences.

9. _________ Individuals may develop a tolerance to, and /or dependence on 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. Ferraro.

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

11. _________ Symptoms of marijuana overdose include, but are not limited to, nausea, vomiting, hacking cough, disturbances in heart rhythms, numbness in hands, feet, arms or legs, anxiety attacks and incapacitation. If I experience these symptoms, I agree to contact Dr. Ferraro immediately or go to the nearest emergency room.

12. _________ 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. Ferraro immediately or go the nearest emergency room if these symptoms occur.

13. _________ I understand that medical marijuana may have serious risks and may cause low birthweight or other abnormalities in babies. I will advise Dr. Ferraro if I become pregnant, try to get pregnant or will be breastfeeding.

The approved conditions in Pennsylvania for the use of Medical Marijuana include the following:

ALS, Autism, cancer, Crohn's disease, Damage to the nervous tissue of the spinal cord with objective neurological indication of intractable spasticity, epilepsy, glaucoma, HIV/AIDS, Huntington's disease, Inflammatory Bowel Disease, Intractable Seizures, Multiple Sclerosis, Neuropathies, Parkinson's Disease, PTSD, Severe chronic or intractable pain of neuropathic origin or severe chronic or intractable pain with conventional therapeutic intervention and opiate therapy is contraindicated or ineffective, and Sickle cell anemia.

My qualifying condition for the use of medical marijuana is ________________________. I understand that if I violate any of this agreement's terms, my physician may stop authorization of my use of cannabis.

12. _________ I have had the opportunity to discuss these matters with Dr. Ferraro and to ask questions regarding anything I may not understand or that I believe needed to be clarified. I acknowledge that Dr. Ferraro has informed me of the nature of a recommended treatment, including but not limited to, any recommendation regarding medical marijuana. Dr. Ferraro has 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. Ferraro informed me of any alternatives to the recommended treatment, including the alternative of no treatment, and the risks and benefits.

13. _________ Quantity, specifications of treatment will be determined with the expert opinions of pharmacy practitioners, that are specifically trained in medical marijuana dosing and administration at your local dispensary_________________. If there are any adverse effects I will stop the medication and notify Dr. Ferraro of them.

14. _________ When under the influence and/or in possession of cannabis in public, a copy of your recommendation/certification should be on your person at all times.

15. _________ In order to stay in compliance with the Pennsylvania State Medical Board regulations, it is required that you return to your recommending physician for a review of your medical condition and an update of your recommendation. If you are overdue for your visit, you will be charged an additional fee. An outdated recommendation may place the Doctors Medical License in Jeopardy with the Medical Board, and the patient is at risk of being ticketed and arrested if in possession of marijuana and an outdated certificate. If such an incidence occurs, you will be charged an additional fee of $500.00 for any services rendered by Dr. Ferraro. Extensions can be given for personal emergency or special circumstances. I agree to have an office visit and medical assessment at least every _____ months. During the first year of Treatment Dr. Ferraro will see you 2 months after starting therapy and then prior to recertification.

16. _________ Patients giving any dishonest or untruthful information will be discharged.

17. _________I agree to not distribute my marijuana to any other person, for personal use or for sale. I am aware that redistribution of any marijuana for sale is an illegal activity.

18. I am aware that using marijuana is associated with psychosis in persons who are still undergoing neurodevelopment (brain growth). Therefore, I will ensure that no person under the age of 25 years has access to my marijuana.

19. I agree to the safe storage of my marijuana.

20. I will not use controlled substances that were prescribed by another doctor unless Dr. Ferraro and my primary care physician is aware of this.

21. I understand that my physician may not be knowledgeable about all of the risks associated with the use of non-FDA approved substances like marijuana.

22. I accept full responsibility for any and all risks associated with the use of marijuana, including theft, altered mental status and side effects of the product.

23. I am aware that my physician may discontinue authorizing marijuana for my condition if he or she assesses that the medical and mental health risk or side effects are too high.

24. I agree to purchase my marijuana only from a licensed dispensary. I am aware that the possession of marijuana from other sources is illegal.

25. I am aware that any possible criminal activity related to my marijuana use may be investigated by legal authorities. During the course of an investigation, legal authorities have the right to access my medical information with a warrant.

26. Dr. Katarzyna Ferraro MD, has the right to discuss my health care issues with other health care professionals or family members if it is felt on balance, that my safety outweighs my right to confidentiality.

Name:________________________ Signature:____________________________ Date:_____________

Physician Signature:____

Dr. Katarzyna Ferraro 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** ______________________________