New Patient Packet

Patient Name _____ **Date of Birth** _____

Medical Records Request Form

If you need medical records from your doctor, please fill out this form and give to them.

Patient Name _____ Date of Birth _____

Address _____

Phone Number _____

Dear Dr. _____ I request the following records to be copied:

- **3 most recent History & Physicals, SOAP Notes, Visit Notes, or Progress Notes**
- **3 most recent imaging studies (reports only, please do not reproduce actual images)**
- **Most recent Comprehensive Metabolic Profile (CMP)**

Please deliver my records as follows:

☐ I will pick up my records from your office.

☐ Please mail my records to me at the address above.

Thank you for your assistance in this matter.

Signature: _____ **Date:** _____

RELEAF MEDICAL

Name: _____

Date of Birth: _____ Date: _____

PAST MEDICAL HISTORY

Hospitalizations — Date and Illness/Reason _____

Surgeries — Date and Type, including any body implants such as cardiac stents, heart valves, joint replacements, pacemakers: _____

Ongoing Medical Problems, including asthma, COPD, diabetes, heart disease, heart murmur, hepatitis, HIV/AIDS, hypertension, kidney failure, venereal disease, alcohol or drug addictions, present or previous psychiatric care, Epilepsy/seizure disorder, Cancer, Wasting Syndrome, Crohn's disease, Multiple Sclerosis, Muscular Dystrophy, Glaucoma, Post-Traumatic Stress Disorder/PTSD, Intractable Pain, Severe Muscle Spasms, Muscle Spasticity, Parkinson's disease, or Autism

Allergies — Name Drug and Reaction, including any type of anesthetic:

CLINICAL HISTORY and CONDITION

Indication(s) for Cannabis Treatment
Chief complaint for evaluation of cannabis treatment _____

List of Symptoms — Type / Frequency / Severity

1. _____
2. _____
3. _____

Prior Treatment(s), Duration and Outcome of Treatment _____

RX Medication Name	Dosage	Regimen	Target Symptom

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OTC / Vitamins/ Supplements/ Herbals/ Homeopathies / Other Self Medication

Medication Name	Dosage	Regimen	Target Symptom

Are you currently taking Aspirin, Coumadin, Plavix, Persantine, or other blood thinners?

Preventative Care — List Ongoing Medical Treatments, Special Diets, Physical Therapies, etc.

If Female, Are You Currently Pregnant or Think That You May Be? ❑ YES ❑ NO

Date of Last Menstrual Cycle _____

Are You Planning on Getting Pregnant? ❑ YES ❑ NO

Are you currently Breast-Feeding? ❑ YES ❑ NO

FAMILY MEDICAL HISTORY

Hereditary Diseases, Significant Illnesses or Cause of Death of Grandparents/Parents/Children/Siblings/Aunts/Uncles/Cousins, example allergy/bleeding disorders/cancer/heart disease/sickle cell anemia/psychiatric problems such as anxiety/bi-polar/depression, etc.

NUTRITIONAL HISTORY

Special Dietary Needs _____

SOCIAL HISTORY and HABITS

Coffee ____ cups/day Tea ____ cups/day Alcohol ____ drinks/day/week Tobacco ____ cigarettes/day

How Many Years Have You Been Smoking? If You Quit, When Did You Stop? _____

Do You Currently Use Marijuana? ❑ YES ❑ NO

If YES, how often and by what method, does it help alleviate the symptoms of your qualifying condition? _____

Recreational Drug Use — Frequency/Type/Route, i.e. ingestion, injection, snorting _____

RELEAF MEDICAL

Notice of Privacy Practices Patient Acknowledgment
Authorization for Use/Disclose of PHI

Patient Name: _____ Date of Birth: _____

Acknowledgment of Privacy Notice

I have received the practice's Notice of Privacy Practices. The Notice provides in detail the uses and disclosures of my PHI (Protected Health Information) that may be made by this practice. I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all PHI at, or controlled by, this practice. I understand I can obtain this practice's Notice of Privacy on request.

Authorization for Use/Disclose of Protected Health Information (PHI)

I authorize the use and disclosure of all health information for the purpose of treatment, payment and Health Care Operations. I authorize Dr. _____ and his staff to use these disclosures of my health information without limitation. I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected. I understand that any revocation does not apply to disclosures or use of PHI that have occurred prior to my revocation. In addition, I authorize disclosure of my PHI to the following individual(s):

_____

List any person(s) that you are allowing this office to communicate with regarding your PHI

Patient Manner of Contact

In general the HIPAA Privacy rule gives individuals the right to request a restriction on uses and disclosures of their PHI. I understand that verbal request is a acceptable authorization for the use of any alternate contact method, number and/or location as well as to change in the manner listed below(i.e. if patient leaves message with contact number and / or location, other than listed below). I understand that this practice calls to confirm appointments at the number I give.

****I Wish to be Contacted in the Following Manner**

_____ NO RESTRICTION (Okay to contact home and/or work and leave detailed message)

_____ Email

_____ Home ONLY Message To Return Call To Doctor's office

_____ Cell ONLY Message To Return Call To Doctor's office

_____ Other _____

I understand that by signing this form I am confirming my receipt of the Notice of Privacy Practices; authorization for method of contact; and authorization for use and/or disclosure of my PHI.

Signature _____ **Date** _____

Relationship to Patient, if signed by a personal representative i.e. parent, legal guardian, etc

_____

RELEAF MEDICAL

Agreements, Disclosures and Informed Consent

I, _____, (Patient's Name), understand that medical marijuana is a medicine used in treating the suffering caused by serious and debilitating medical conditions. Serious and debilitating medical conditions include: Cancer, HIV/AIDS, Epilepsy, Multiple Sclerosis, Parkinson's disease, ALS (Lou Gehrig's disease), damage to the nervous tissue of the spinal cord with objective neurological indication of intractable spasticity (any spinal cord injury), Inflammatory Bowel Disease, Huntington's disease, any type of neuropathy; any condition that is severe, for which other medical treatments have been ineffective, and if the symptoms "reasonably can be expected to be relieved" by the use of medical cannabis. Additionally, medical marijuana is used in the treatment of other chronic or persistent medical symptoms that:

- Substantially limits the ability of the person to conduct one or more major life activities as defined in the Americans with Disabilities Act of 1990 (Public Law 101-336)
- If not alleviated, may cause harm to the patient's safety or physical or mental health
- A chronic or debilitating disease or medical condition that causes severe loss of appetite, wasting, severe or chronic pain, severe nausea, seizures or severe or persistent muscle spasms, or glaucoma or post-traumatic stress disorder (PTSD)

I have been advised that the use of medical marijuana may affect my coordination, motor skills and cognition in 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 body's immune system, increased talkativeness, impairment of motor skills, delayed reaction time, loss of physical coordination, paranoia, and increased 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 that chronic use of medical marijuana may lead to laryngitis, bronchitis and general apathy.

I understand that although marijuana does not produce a specific psychosis, it may exacerbate schizophrenia in persons predisposed 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 taken 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 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 legal 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 3-4 months. If I think I may be developing a tolerance to 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 its 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 chemicals known as tars that may be harmful to my health. I understand that there are many methods of intake that substantially reduce the harmful effects of smoking such as vaporizers, edibles, tinctures, etc.

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MEDICAL

I understand marijuana varies in potency. The effects of marijuana may also vary 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 your 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 and to 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 using marijuana and that I can get a DUI for driving under the influence.

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

I am not permitted to smoke within 1,000 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 agree to follow up with the attending physician at _____ with supporting medical records pertaining to my medical conditions.

I understand the attending physician, staff and or representatives of Releaf Medical are neither providing, dispensing nor encouraging me to obtain medical marijuana. I also acknowledge that the attending physician, staff and or representatives will NOT be providing or discussing information regarding dispensary, co-op, delivery service or any other way to obtain marijuana.

I certify that I have 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, the letter of recommendation will result in the immediate termination 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 Releaf Medical 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 behalf, hold the physician and 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:** _____

RELEAF MEDICAL

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 Dr. _____ and his staff to converse of my medical condition.

I understand that I must be a **Louisiana** resident to obtain an approval or recommendation for the use of medical cannabis.

I affirm that I have 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.

I, the undersigned, hereby request a consultation by the physician for purposes of determining the appropriateness of medicinal 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 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 possible 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 Name (Print)_____**Date**_____

Patient Signature _____**Date**_____

RELEAF MEDICAL

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 intend 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 HIPAA regulations and patient/ doctor confidentiality.

I am aware that my recommendation can be revoked at any time and legal action 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 Releaf Medical or it's representative, to discuss my medical 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 or 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) _____ **Date** _____

Patient Signature _____ **Date** _____

HIPAA Notice of Privacy Practices Acknowledgment of Receipt

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

Authorization for Release of Confidential Records

I _____, date of birth_____, hereby authorize Releaf Medical to disclose and verify me as a patient to any law enforcement agency, my physician(s),Child Protective Services or any Louisiana State approved 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 Releaf Medical and the attending physician permission to validate my status as a patient using the Releaf Medical online patient verification system.

I give permission for my medical records and file to be reviewed by another physician working with Releaf Medical. I understand that this might happen if the original doctor that evaluated me requires a secondary opinion, is not available, off premise, 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 questions to the best of my ability.

Physician Signature_____**Date** _____

RELEAF MEDICAL

Authorization For Use/Disclosure of Health Information

Name:_____ **Date of Birth:**_____

Authorization for Use/Disclosure of Information: I voluntarily authorize and direct my health care provider (Please insert name of provider) _____ to use or disclose my health information during the term of this Authorization to the recipient that I have identified below.

Recipient: Name of person or class of persons to whom my health care provider may disclose my health information

_____

Address or Fax # of the recipient or where my health information should be delivered: _____

_____

Purpose: I understand that the specific purpose of this Authorization is _____

_____

(Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization)

Information to be disclosed: This authorization permits the above provider to disclose the following medical records: **YES / NO** All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me. **NOTE: This Authorization does not extend to HIV test results, outpatient psychotherapy notes, drug or alcohol treatment records that are protected by federal law or mental health records that are protected by the Lanterman-Petris-Short Act.** All of my health information described above except for the following:

_____

Only the following records or types of health information (Insert dates of treatment, types of treatment or other designation.)

_____

DISCLAIMER: No insurance can be billed on your behalf without this signed Authorization. Same day of service payment in-full is required for any services provided.

Privacy Practices: By signing this Authorization, you acknowledge that our Notice of Privacy Practices has been provided to you.

Term: This Authorization will remain in effect:

- Until the Provider fulfills this request.
- Until the following event occurs: Indefinitely, until I revoke or restrict this Authorization.

Redisclosure: I understand that once my heath care provider discloses my health information to the recipient identified above, my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health care provider.

Revocation: I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to my health care provider's Privacy Office at the address listed below. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

Signature	**Date**	**Signature of Witness**

If the individual is unable to sign this Authorization, please complete the information below:

Name of Guardian/Representative	**Relationship**	**Witness**	**Date**

RELEAF MEDICAL

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 controlled 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 Louisiana, 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 marijuana use registry identification card in his of 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. _____.

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

_____ 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 memory, euphoria, difficulty in completing complex task, 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 judgement. Many medical authorities claim that use of medical marijuana, especially by persons your than 25, can result in long-term problems with attention, memory, learning, drug abuse, and schizophrenia.

_____ I understand that using medical 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.

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 call 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 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. _____ if I become pregnant, try to get pregnant, or will be breast feeding.

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 for cancers, for cancers, including glioma.

  There is evidence to suggest that cannabinoids may play a role in the cancer regulation processes. Due to 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 - included nausea and vomiting.

_____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 for 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.

_____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 deeps, 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 cf 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.

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 I have been informed 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 I have been informed of any alternatives to the recommended treatment, including the alternative of no treatment, and the risk 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:** _____

There does not appear to be good, quality primary literature that medical marijuana or cannabinoids are 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 with HIV/AIDS.

_____Post-traumatic stress disorder

- There is limited evidence (a single, small fair-quality trial) that nabilone is effective for improving symptoms of post traumatic 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 post traumatic stress disorder symptoms among individuals with post traumatic stress disorder.

_____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, 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.

_____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 clinical - measured spasticity.

Based on evidence from randomized controlled trials included in systematic review, 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 clinical-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 medical 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 evaluated cannabis in flower form 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.