

Dr. CANNABIS COMPASSIONATE CLINIC ACKNOWLEDGEMENT OF DISCLOSURE & INFORMED CONSENT

Please read each item below and initial in the space provided to indicate that you understand and agree with the information regarding the risks and side effects of using cannabis medicines.

Do not sign this agreement and do not use medical cannabis if you have questions about or do not understand the information you have received. Please tell the staff at Dr. Cannabis Compassionate Clinic & Wellness Center if you do not understand any of the information provided.

Patient's Name _____ DOB ____/____/____

Address _____

City _____

Zip Code _____

DISCLOSURES:

✓The cannabis plant is not regulated by the United States Food and Drug Administration and therefore may contain unknown quantities of active ingredients, impurities or contaminants. _____(initial)

✓The efficacy and potency of cannabis may vary widely depending on the cannabis strain and ingestion method. Estimating the proper cannabis dosage is very important. _____(initial)

✓Smoking cannabis can cause respiratory harm, such as chronic bronchitis. Many researchers agree that cannabis smoke contains known carcinogens (chemicals that can cause cancer), and that smoking cannabis may increase the risk of respiratory diseases and cancers of the lungs, mouth and tongue. _____(initial)

✓Vaporizers may substantially reduce many of the potentially harmful smoke toxins that are normally present in cannabis smoke. _____(initial)

✓Side effects of medical cannabis can include, but are not limited to: _____(initial)

- Short term memory loss
- Anxiety/Nervousness
- Irregular heartbeat
- Dry mouth
- Slower reaction time /inability to concentrate
- Suppression of immune system
- Poor physical condition
- Hunger/Loss of appetite
- Cough/bronchitis/shortness of breath
- Dependency
- Dizziness
- Confusion
- Impaired vision

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- Feelings of euphoria
- Drowsiness/fatigue/abnormal sleep
- Headache/nausea/vomiting
- Depression
- Numbness
- Laryngitis
- Agitation
- Low blood pressure
- Paranoia/psychotic symptoms
- Impairment of motor skills

●Sedation

●Symptoms of cannabis overdose include but are not limited to nausea, vomiting, disturbances to heart rhythm. _____(initial)

●For some patients, chronic cannabis usage can lead to laryngitis, bronchitis and general apathy. There is little known regarding how cannabis may, or may not, react with other pharmaceutical or herbal medications. _____(Initial)

●Some patients can become dependent on cannabis. This means they experience withdrawal symptoms when they stop using cannabis. Signs of withdrawal symptoms can include feelings of depression, sadness or irritability, restlessness or mild agitation, insomnia, sleep disturbance, unusual tiredness, trouble concentrating, and loss of appetite. _____(initial)

●Some users develop a tolerance to cannabis. This means higher and higher doses are required to achieve the same symptom relief. _____(initial)

●The possibility exists that cannabis may exacerbate schizophrenia in persons predisposed to that disorder. _____(initial)

●Using cannabis while under the influence of alcohol is not recommended. _____(initial)

●The use of cannabis may affect coordination and cognition in ways that would very likely impair an ability to drive, operate heavy machinery, or engage in potentially hazardous activities. _____ (initial)

Medical Cannabis Patient Agreement:

✓I have read and understand the foregoing disclosures and have initialed next to each to acknowledge this understanding. _____(initial)

✓I have been further advised that cannabis smoke contains chemicals known as tars that may be harmful to my health. _____(initial)

✓I understand that side effects may occur while I am taking cannabis medicines. _____(initial)

✓In the event of overdose, I am advised to contact my authorized prescriber. In the event the authorized prescriber is not available, I agree to call 911 for help and I am advised to lie down, relax, and rest until help arrives. _____(initial)

✓I agree to tell my prescribing physician if I have ever had symptoms of depression, been psychotic, attempted suicide or had any other mental problems. I also agree to tell my prescribing physician if I have ever been prescribed or taken medicine for any of these problems. _____(initial)

✓I understand that my attending or prescribing physician does not suggest nor condone that I cease treatment of medications that stabilize my mental or physical condition. _____(initial)

✓If I start taking medical cannabis, I agree to tell my prescribing physician if I (any one or more of the following): _____(initial)

- Start to feel sad or have crying spells
- Have changes in my normal sleep patterns
- Lose my appetite
- Become more irritable than usual
- Become unusually tired
- Withdraw from family and friends
- Lose interest in my usual activities
- Should respiratory problems or other ill effects be experienced in association with the use of medical cannabis, I agree to discontinue its use and report any such problems or effects to my prescribing physician. _____(initial)
- I understand that Dr. Cannabis Clinic & Wellness Center and its employees are not encouraging me to obtain medical cannabis. _____(initial)
- I understand that if I have any respiratory conditions such as Asthma, Allergies, or COPD that smoking cannabis will make my respiratory illness worse. _____(initial)

Release of Liability

I hereby acknowledge Dr. Cannabis Compassionate Clinic & Wellness and its employees are not addressing specific aspects of my medical care nor are any of them my primary care provider. Furthermore, I, for myself, my heirs, assigns, or anyone acting on my behalf, hold Dr. Cannabis Clinic & Wellness Center and its 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 cannabis use. _____ (initial)

I certify that I fully understand the potential risks and side effects related to the use of cannabis as described above. _____ (initial)

In using cannabis for medicinal use, I fully accept responsibility and assume the risks and side effects associated with its use. _____(initial)_

I agree that Dr. Cannabis Clinic & Wellness Center and employees shall not be held responsible for any harm resulting to me and/or any other individual(s) as a result of my medicinal usage of cannabis. _____ (initial)

I certify that I have read this document and declare under penalties of perjury that the information contained herein is true correct and complete. _____ (initial)

Patient's Signature _____

Date _____

Witness Signature: _____