

INFORMED CONSENT FOR MEDICAL MARIJUANA THERAPY

I _____ am being evaluated for a physician's recommendation for the medicinal use of 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)

1. _____ The federal government currently has marijuana classified as a Schedule 1 Controlled Substance. Schedule 1 substances are defined as having (1) a high potential for abuse; (2) no currently accepted medical use in treatment; 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 which have laws that allow marijuana use as a medication.
2. _____ Marijuana has not been approved by the Food and Drug Administration for marketing as a drug. Therefore the production of marijuana for medical use is not subject to any standards, quality control, or other oversight. Marijuana may contain unknown quantities of active ingredients, impurities, contaminants, and substances in addition to THC, the main psychoactive component of marijuana.
3. _____ The use of marijuana may affect coordination, motor skills and cognition. While using marijuana I agree that I should not drive, operate heavy machinery or engage in any activity that requires me to be alert and/or respond quickly. I understand that if I drive while under the influence of marijuana, I may be arrested for "driving under the influence".
4. _____ Potential side effects of marijuana use 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 immune system, 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, marijuana may cause me to talk or eat in excess, alter my perception of time and space and impair my judgment. Some medical authorities claim the use of marijuana especially by persons younger than 25 years old, can result in long term problems with attention, memory, learning, a tendency to abuse other drugs, and schizophrenia.
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.
6. _____ I agree to contact my provider, Amy Lane APRN, if I experience any of the side effects listed above or if I become depressed, psychotic, or have suicidal thoughts. I will also contact said medical provider if I develop any respiratory problems, changes in my normal sleep patterns, increased irritability, or begin to withdraw from my family 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 carcinogens and smoking marijuana may increase the risk of respiratory diseases and cancers in the mouth, tongue, and lungs. In addition marijuana smoke contains harmful chemicals known as tars. If I begin to experience any 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 any medication or am undergoing treatment for any medical condition, I understand that I should consult my treating physician(s) before using medical marijuana and that I should not discontinue any medication or treatment that was previously prescribed unless advised to do so by the treating physician(s).
9. _____ Individuals may develop a tolerance to and/or a dependence on marijuana. I understand that if I require increasingly higher doses to achieve the same benefit or if I think I am developing a dependency to marijuana, I will contact Amy Lane APRN, LLC.
10. _____ Signs of marijuana withdrawal may include; feelings of depression, 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 rhythm, numbness in the hands, feet, arms or legs. If I experience any of these symptoms, I agree to go to the nearest emergency room and contact Amy Lane APRN, LLC.
12. _____ If my medical provider, Amy Lane APRN, subsequently learns that the information I have furnished is false or misleading, the recommendation for medical marijuana may no longer be valid.
13. _____ I have had the opportunity to discuss these matters with Amy Lane APRN, and to ask any 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. I have been informed of the risks, complications, and expected benefits of any recommended treatment, including its likelihood of success or failure. I acknowledge that my medical provider, Amy Lane APRN, has informed me of any alternatives to the recommended treatment, including the alternative of no treatment, and the risks and benefits.
14. _____ Patients giving dishonest or untruthful information will be discharged from care.

Patient Name: _____

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

AMY LANE, APRN