Patient Information and Consent for Medicinal Cannabis

Patient (full) Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­

**What is a Medicinal** **Cannabis?**

* There are significant differences between pharmaceutical products derived from cannabis and the consumption of marijuana for the purposes of getting high. Medicinal cannabis is derived from the cannabis plant by using isolated cannabinoids (such as CBD and TCH) that help treat/manage varies medical conditions. Medicinal Cannabis does not give the patient a high after administration.

**Contraindications for THC only**

* Hypersensitivity to any cannabinoid or products used in manufacture (e.g. sesame oil).
* Have severe and unstable cardiopulmonary disease (angina, peripheral vascular disease, cerebrovascular disease, and arrhythmias) or risk factors for cardiovascular disease.
* Have a previous psychotic or concurrent active mood disorder or anxiety disorder
* Are pregnant/breastfeeding

**Possible side effects for CBD and TCH Possible side effects for TCH (ONLY)**

* Dizziness / fatigue / vertigo
* Drowsiness / sedation / dry mouth
* Vomiting / nausea / diarrhoea / fever
* Convulsions / confusion / psychosis
* Hallucinations / delusions / depression
* Problems with thinking and memory

**What if I am pregnant or become pregnant?**

* Medicinal Cannabis in the form of THC is contraindicated in pregnant women. Studies have shown that it can induce pre-term labour, low birth weight and it contaminates breast milk.
* Therefore, if you are pregnant or became pregnant please advise your doctor so further advise can be provided.

**QUESTION – please answer**

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| --- |
| **What is the primary diagnosis or medical condition for which you seek treatment with medicinal** **cannabis?**  |
| * Chronic pain
 | * Migraine / Epilepsy
 |
| * Anxiety, depression, or Chronic insomnia
 | * Neuropathic pain
 |
| * Chemotherapy-induced nausea and vomiting
 | * Cancer / palliative pain
 |
| * Other ­­­­­­­­­
 |

**Have you ever self-medicated or are currently self-medicating with cannabis**? YES / NO

**Are you pregnant, breastfeeding, or considering pregnancy?** YES / NO / NA

**What other treatment have you tried for the condition?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**What medications have you previously used? List any side effects and your reason for stopping.** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- |
| **Do you currently experience, or have a history of the following?**  |
| * Psychosis
 | * Bipolar disorder
 |
| * Mood disorder or severe anxiety
 | * Cardiovascular disease
 |
| * Drug dependence or substance abuse
 |  |

**PATIENT DECLARATION – please tick**

|  |  |  |
| --- | --- | --- |
|  | **YES** | **NO** |
| **1** | I understand that the long-term effects of medicinal cannabis is unknown. |  |  |
| **2** | I confirm that my doctor has provided me with information about the medicinal cannabis product, its concentration, its dosage, how to use it, who to take it, how to store the medicinal cannabis product and the proposed duration of treatment. \*medicinal cannabis is stored at room temperature away from sunlight.  |  |  |
| **3** | I understand that the prescribing doctor will report my treatment outcomes to the government. |  |  |
| **4** | I understand that the cost of medicinal cannabis is solely my responsibility. |  |  |
| **5** | I understand that I must not drive or operate machinery whilst taking medicinal cannabis containing THC. If I drive or operate under these circumstances, I am breaking the law. I understand that a legally issued prescription does not provide a defence to such an offence in the court of law.  |  |  |
| **6** | I understand that risks and complications associated with medicinal cannabis treatment. I agree to follow my doctor’s recommendations regarding dosing. I agree to report any adverse effects I experience from taking medicinal cannabis, including but not limited to changes in level of sedation, lethargy, fatigue, dry mouth, nausea, vomiting, diarrhoea, drowsiness, dizziness disorientation, agitation, balance problems, changes in memory, paranoid delusions or hallucinations.  |  |  |
| **7** | I understand that there is a possibility of unknown risk and side effects. |  |  |
| **8** | I understand that medicinal cannabis might interact with my other medications, and doses may need to be adjusted accordingly.  |  |  |
| **9** | I agree to attend regular follow-up consultations in the clinic or over the phone as directed by my doctor and with other healthcare providers.  |  |  |
| **10** | I agree to keep a log of my doses and changes in symptoms due to medicinal cannabis. |  |  |
| **11** | I agree that I will not use any form of cannabis other than that prescribed by my doctor, including any illicit form of cannabis (marijuana). |  |  |
| **12** | I agree to notify my prescribing doctor of any changes in my other medications. |  |  |
| **13** | I agree to share my clinic outcomes for research purposes. |  |  |
| **14** | I agree to under take regular blood tests and to avoid the use of alcohol or any use of illicit and unprescribed drugs.  |  |  |

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have read and understood the above information and have been given the opportunity to ask any questions that I may have in relation to medicinal cannabis, such as but not limited to contraindications and side effects. By signing this consent form, I acknowledge that the information above has been checked with and understood by me and I therefore consent to the medicinal cannabis.

Patient’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Doctor’s Declaration**

I declare that I have personally discussed this form with the patient, including the patient’s condition, the need for the treatment/procedure, the risks and alternatives outlined on pages 1 and 2.

I confirm that I have given the patient the opportunity to ask questions which I have answered as

fully as possible.

Prescribing Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Prescriber Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_