HEALTHSPAN MEDICAL SYSTEMS

PATIENT IN-TAKE FORM

DATE: _____

Patient:	DOB:
Street:	Cell:
City/State/Zip:	SSN:
Phone:	
Email:	
Primary Physician:	Phone:
Pharmacy Address:	Phone:
Emergency Contact:	Relationship:
Street:	Phone:
City/State/Zip:	

PAST MEDICAL HISTORY

Hospitalizations: Date & Illness/Reason: _____

_____

_____

_____

Surgeries: Date & Type (including any body implants or ongoing conditions): _____

_____

_____

_____

Ongoing Medical Problems, including asthma, COPD, diabetes, heart disease, heart murmur, hepatitis, HIV/AIDS, hypertension, kidney failure, VD, substance addiction, present or previous psychiatric care:

_____

_____

_____

Allergies (name of drug/substance and reaction, including anesthetics): _____

_____

_____

CLINICAL HISTORY AND CONDITION

Indications/Reason for Cannabis Treatment (chief complaint): _____

_____

_____

_____

List of Symptoms – type, frequency, and severity: _____

_____

_____

_____

Prior treatment(s) duration, and outcome of treatment: _____

_____

_____

_____

RX Medication Name | Dosage | Regimen | Target Symptom: _____

_____

_____

_____

_____

OTC Vitamins | Supplements | Herbals | Homeopathy | Other

Medication Name | Dosage | Regimen | Target Symptom:

_____

_____

_____

_____

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

_____

_____

Preventive Care – List ongoing Medical Treatment, Special Diets, Physical therapies, etc.: _____

_____

_____

_____

_____

If Female: are you currently pregnant, or think that you may be? ☐ YES ☐ NO

Date of last menstrual cycle: _____

Planning to become 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/heart disease/sickle cell anemia/ psychiatric disorders such as anxiety/bi-polar/depression, etc.:

_____

_____

_____

_____

NUTRITIONAL HISTORY

Special Dietary Needs:

_____

_____

_____

_____

SOCIAL HISTORY & HABITS

Coffee _____ cups/day | Tea _____ cups/day

Alcohol _____ drinks/day/week | Tobacco _____ cigarettes/day

How many years have you been smoking? _____ | If quit, how long ago? _____

_____

Do you currently use marijuana? ☐ YES ☐ NO | How often?

If YES, how often and by what method? _____

_____

Does it help alleviate your symptoms? _____

_____

Recreational Drug use – frequency/type/route: ie ingestion, injection, snorting? _____

_____

_____

_____

OFFICE POLICIES

Dr. John DeLuca and staff are dedicated to providing you with the best possible care and services. We have adopted the following financial policies in order to minimize confusion or misunderstanding between our patients and practice.

Participating Insurance

You must provide us with accurate insurance information and allow us to photocopy your insurance card. Any co-payments are due at the time of service. You are ultimately responsible for knowing the requirements and coverage limitations of your own insurance policy. If a referral is required by your plan, it must be presented prior to services. You must ensure that the referral is made to the correct doctor, that it has not expired and that the number of visits have not expired. If you receive services without obtaining a required referral, you will be financially responsible for such services.

Self-Paying Patients

Payments for services are due when services are rendered. If we do not participate in your insurance plan, we will be happy to help you process your claim, and/or provide you with an itemized bill, once all fees are paid.

I have read and fully understand the policies of this office regarding payments and insurance. I agree to pay for services at the time services are rendered. I also understand that I may request a superbill to present to my insurance{s) for reimbursement.

Patient Full Name: _____ Date: _____

Signature of Patient/Guardian: _____

HIPAA Notice of Privacy Acknowledgement 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 acknowledgement will be filed with my records.

Authorization for Release of Confidential Records

I,_____, Date of Birth _____

hereby authorize Dr. John DeLuca to disclose and verify me as a patient to any law enforcement agency, my physician(s], Child Protective Services or any Florida 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 Dr. John DeLuca and the attending physician permission to validate my status as a patient using the Dr. John DeLuca online patient verification system.

I give permission for my medical records and file to be reviewed by another physician working with Dr. John DeLuca. 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:_____

Authorization for Use/Disclosure of Health Information

Name: _____ DOB: _____

Authorization for Use/Disclosure of Health Information: I voluntarily authorize and direct my health care provider to use or disclose my health information (Please information insert name of the provider) _____ 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 this Notice of Privacy Practices has been provided to you.

Term: This Authorization will remain in effect

☐ From the date of this Authorization until the _____day of _____, 20_____;

☐ Until the Provider fulfills the request;

☐ Indefinitely, until I revoke or restrict this Authorization.

(Authorization for Use/Disclosure of Health Information: page 2)

Redisclosure: I understand that once my health care provider discloses my health information to the recipient identified above, my health care provider cannot guarantee that the recipient will not red1sclose 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.
(If individual is unable to sign, please include signer's identification information.)

Signature	Date	Witness
Guardian/Representative	Date	Witness
Guardian/Representative Relationship		

Acknowledgements, Agreements, Disclosures and Informed Consent

I, _____ 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 limit 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.

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.

(Acknowledgements, Agreements, Disclosures and Informed Consent page 3)

I agree that if I am a female patient that 1 will contact my attending physician if I become or are thinking about becoming pregnant. l acknowledge that the use of medical marijuana creates pass-through problems to a fetus during pregnancy and to a baby during breastfeeding.

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 while 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 HealthSpan Medical Systems with supporting medical records pertaining to my medical conditions.

I understand the attending physician, staff and or representatives of HealthSpan Medical Systems 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 HealthSpan Medical Systems 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 _____

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 John DeLuca, MD to converse concerning my medical condition.

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

I affirm that I have a 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.

Florida's Medical Marijuana Legalization Initiative -Amendment 2, approved November 08, 2016 -provides for the possession of medical marijuana for the personal medical purposes of the patient with a physician approval or recommendation. lt should be made clear that the physician, staff, and representatives of this practice are not providing medical marijuana, nor are they encouraging any illegal activity in my obtaining medical marijuana.

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 Signature _____ Date _____

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 actions 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 MarijuanaDoctors.com 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	Phone Number
Patient Signature	Cell Number
Street Address	
City	State Zip

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 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 Florida, 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 medical marijuana use registry identification card in his or 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 i n 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. John DeLuca (name of qualified physician).

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 use.

__ 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, 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 judgment. Many medical authorities claim that use of medical marijuana, especially by persons younger 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. Deluca if I experience any of the side effects

listed above, or if I become depressed or psychotic, have suicidal thoughts, or experience crying spell s. I will also contact Dr. DeLuca 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 contact Dr. Deluca 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. Deluca 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. John DeLuca immediately or go to the nearest emergency room if these symptoms occur.
__ I understand that medical marijuana may have serious risks and may cause low birthweight or other abnormalities in babies. I will advise Dr. DeLuca if I become pregnant, try to get pregnant, or will be breastfeeding.

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, including glioma. There is evidence to suggest that cannabinoids (and the endocannabinoid system more generally) may play a role in the cancer regulation processes. Due to a 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.

There is insufficient evidence to support or refute the conclusion that cannabinoids are an effective treatment for cancer - associated anorexia - cachexia syndrome and anorexia nervosa.

- **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. Randomized trials of the efficacy of cannabidiods for different forms of epilepsy have been completed and await publication.
- **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 drops, 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 of 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 shm.vn only short - term benefit on intraocular pressure (hours), suggesting a limited potential for cannabinoids in the treatment of glaucoma.
- **Positive status for HIV:** There is limited evidence that cannabis and oral cannabinoids are effective in increasing appetite and decreasing Weight loss associated with HIV/ AIDS. here does not appear to be good - quality primary literature that reported on cannabis or cannabinoids as effective treatments for AIDS wasting syndrome.
- **AIDS:** There is limited evidence that cannabis and oral cannabinoids are effective in increasing appetite and decreasing weight loss associated with HIV/AIDS. There does not appear to be good - quality primary literature that reported on cannabis or cannabinoids as effective treatments for AIDS wasting syndrome.
- **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. There are other trails that are in the process of being conducted and if successfully completed, they will add substantially to the knowledge base.
- **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, the 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. Evidence suggests that the endocannabinoid system plays a meaningful role in certain neurodegenerative processes; thus, it may be useful to determine the efficacy of cannabinoids in treating the symptoms of neurodegenerative diseases. Small trials of oral cannabinoid preparations have demonstrated no benefit compared to a placebo in ameliorating the side effects of Parkinson1s disease. A seven-patient trial of nabilone suggested that it improved the dyskinesia associated with levodopa therapy, but the sample size limits the interpretation of the data. An observational study demonstrated improved outcomes, but the lack of a control group and the small sample size are limitations.
- **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 reviews, 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:** 1) The qualifying physician has provided the patient or the patient's caregiver a summary of the current research on the efficacy or marijuana to treat the patient's medical condition and 2) 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:** 1) The qualifying physician has provided the patient or the patient's caregiver a summary of the current research on the efficacy or marijuana to treat the patient's medical condition and 2) 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 them evaluated cannabis in flower form provided 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.

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 Dr. DeLuca has informed me of the nature of a recommended treatment, including but not limited to, any recommendation regarding medical marijuana.

Dr. DeLuca 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. DeLuca informed me of any alternatives to the recommended treatment, including the alternative of no treatment, and the risks and benefits.

Dr. DeLuca has explained the information in this consent form about the medical use of marijuana.

Patient signature or signature of the parent or legal guardian if the patient is a minor:

Signature	Date
Guardian/Representative	Date
Guardian/Representative Relationship	

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