PRECISION PAIN CARE

Tel: 740.689.9500

Ronald P. Linehan MD
Carter Battista DO

Acknowledgements, 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 including: 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, Chronic wasting, Cachexia, severe or chronic pain, seizures or severe or persistent muscle spasms, glaucoma or post-traumatic stress disorder (PTSD}; Chronic Migraines, Arthritis, Complex Regional Pain Syndrome, any type 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 if not alleviated, may cause harm to the patient's safety or physical or mental health.

_____ 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 Ohio, which have modified their state laws to treat marijuana as a medicine. 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.

_____ 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 those risks.

_____When in 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.

_____ 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. It is recommended for patients to have an intermission with the drug for at least 3 weeks every 3 4 months. 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 Precision Pain Care.

_____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."

_____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 judgement. 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. 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.

_____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.

_____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 Precision Pain Care 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.

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_____ 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 understand that medical marijuana may have serious risks and may cause low birthweight or other abnormalities in babies. I will advise Precision Pain Care if I become pregnant, try to get pregnant, or will be breastfeeding.

_____Chronic use of medical marijuana may lead to laryngitis, bronchitis. 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 contains chemicals known as tars that may be harmful to my health.

_____ I understand that although medical 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 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 breastfeeding.

_____ I agree to contact Precision Pain Care or go to the Emergency Department 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 Precision Pain Care 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.

_____I understand the attending physician, staff and/or representatives of Midwest Health and Wellness Center 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 Precision Pain Care 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.

_____ I agree to follow up with the attending physician at Precision Pain Care with supporting medical records pertaining to my medical conditions.

_____I understand the information in this consent form about the medical use of marijuana.

Patient Signature_____ Date_____

Patient Printed Name _____

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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 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 Precision Pain Care or its 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.

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 Midwest Health and Wellness Center, LLC to converse of my medical condition.

I understand that I must be an Ohio 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, regardless of my marijuana card status, I am still subject to all Ohio laws including driving while under the influence of any intoxicating substance, and my ability to legally own and carry firearms. I am still subject to all of my employers conditions of employment. I am solely responsible for fully understanding all Ohio laws regarding the use of Medical Marijuana. I completely absolve Precision Pain Care from any liability from any undesirable outcomes related to my consumption of Marijuana.

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 cannabis use. 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_____

Patient Printed Name _____