SAMPLE MEDICAL MARIJUANA TREATMENT AGREEMENT

Because we take our responsibilities to authorize and supervise the medical use of marijuana very seriously, we ask you to read, understand, and sign this form.

1. I request Dr.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MD to prescribe marijuana to me under the Health Canada MMPR legislation so that I may legally use marijuana to treat my medical condition.

2. I agree to receive a prescription for marijuana only from one physician, Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MD.

3. I agree to consume no more marijuana than what is prescribed to me by Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MD. I will not request a refill of my prescription prior to the agreed upon refill date.

4. I agree to not distribute my medical marijuana to any other person, for personal use or for sale. I am aware that redistribution of any marijuana for sale is an illegal activity.

5. I am aware that cannabis is associated with psychosis in persons who are still undergoing neurodevelopment (brain growth). Therefore, I will ensure that no person under the age of 25 years has access to my medical marijuana.

6. I agree to the safe storage of my medical marijuana.

7. I am aware that co-ingestion of substances, especially sedating substances, may cause harm and possibly even death. I will not use illegal drugs (e.g. cocaine, heroin) or controlled substances (e.g.narcotics, stimulants, anxiety pills) that were not prescribed for me.

8. I will not use controlled substances that were prescribed by another doctor unless Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MD is aware of this.

9. I agree to witnessed urine, saliva, or blood tests when requested.

10. I agree to have an office visit and medical assessment at least every \_\_\_\_\_\_\_\_\_\_ (months or weeks).

11. I understand that Health Canada has provided access to marijuana by prescription through a physician for the treatment of certain medical conditions, but despite this, Health Canada has not approved marijuana as a registered medication in Canada.

12. I understand that my physician may not be knowledgeable about all of the risk associated with the use of a non-Health Canada approved substance like marijuana.

13. I agree to communicate to my prescribing physician any experiences of altered mental status or possible medical side effects of the use of marijuana.

14. I accept full responsibility for any and all risks associated with the use of marijuana, including theft, altered mental status, and side effects to the medication.

15. I am aware that marijuana use is not advisable during pregnancy and breastfeeding. I agree to inform my physician if I am pregnant.

16. I am aware that smoking any substance can cause harm and medical complications to my breathing and respiratory status. I will avoid smoking marijuana. I will avoid mixing marijuana with tobacco. I agree to use my medical marijuana only by vaporizer or edible products.

17.I am aware that my physician may discontinue the prescribing of marijuana if they assess that medical or mental health risk or side effects are too high.

18. I agree to see specialists or therapists about my condition at my doctor’s request.

19. I agree to avoid driving a vehicle or operating heavy machinery for at least 4 hours after the use of marijuana or longer if I feel any persistent negative effects on my ability to drive.

20. As per the Health Canada MMPR legislation, I agree to purchase my marijuana only from a Licensed Producer (LP). I am aware that possession of marijuana from other sources is illegal.

21. I am aware that any possible criminal activity related to my marijuana use may be investigated by legal authorities and criminal charges may be laid. During the course of an investigation, legal authorities have the right to access of my medical information with a warrant.

22. Violation of any of the terms of this contract may result in its termination for prescribing for medical marijuana.

23. Dr.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MD has the right to discuss my health care issues with other health care professionals or family members if it is felt, on balance, that my safety outweighs my right to confidentiality.

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Patient’s Printed Name Patient’s Signature

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Date Practitioner’s Signature