reTHINK CANNABIS

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CONSENT TO TREATMENT (MEDICAL CANNABIS)

I, _____, am seeking treatment for the purpose of relieving symptoms of _____.
I have reviewed medical alternatives as well as understand the potential risks/ benefits/ potential side effects of medical cannabis as well as potential drug interactions and acknowledge that the benefits of medical cannabis outweigh its use.

I understand that cannabis may impair my ability to drive by having an effect on my coordination, motor skills, and cognition.

I understand that although medical cannabis is legal in the States of Florida and Pennsylvania, there may be implications in my workplace if it is prohibited and that may include termination of employment.

I acknowledge that cannabis is allowed for medical treatment under Florida and Pennsylvania statutes, however it is considered to be illegal by the Federal Government due to its classification as a schedule I drug, and I assume all risks and responsibilities.

I confirm an understanding that my de-identified health information contained in the physician certification and medical use registry may be used for research purposes.

I understand that if I am at risk of becoming pregnant I will use a form of contraception or abstain from using medical cannabis. I understand medical cannabis is contraindicated in pregnancy or while breast feeding.

I understand the purpose of this consultation is to assess the risk versus benefits of medical cannabis in relationship to my qualifying condition. I understand this evaluation should not replace any screening or follow up with my primary care physician or other consultants. I understand that there is no scientific data regarding specific dosing of CBD (cannabidiol) or medical cannabis and that the physician only provides a recommendation per state guidelines specifying a maximum dose per day.

Signature_____ Date _____