Agreement for Medical Cannabis
Lancaster Medical

1. I understand that I am entering into an agreement with my physician concerning the use of Medical Cannabis for the treatment of _____.
2. I have been advised that the purpose of this agreement is to avoid misunderstandings about the medications I will be taking, and to comply with the law regarding medical cannabis.
3. Medication(s) and dosage(s) prescribed: _____
   _____
4. The nature and purpose of the use of medical cannabis have been fully explained to me. I have also been informed of expected benefits and complications (from known and unknown causes), discomforts and risks that may arise, as well as possible alternatives to the proposed use of medical cannabis, including not using it. The risks of the alternatives to the proposed use of medical cannabis have also been discussed. I have been given an opportunity to ask questions, and all of my questions have been answered fully and satisfactorily. I understand that no guarantees have been made to me about the results of using medical cannabis.

Risks and Potential Side Effects

5. The potential side effects of cannabis include, but are not limited to: facial flushing, red eyes, dry mouth, drowsiness, sedation, dizziness, fainting, clumsiness, confusion, fuzzy thinking, impaired attention, impaired concentration, impaired short term memory, agitation, anxiety, paranoia, delusions, hallucinations, amnesia, fast or slow heartbeat, or severe allergic reaction which can include breathing difficulties that in rare circumstances can become very severe or immediately life threatening.
6. When I first start taking cannabis, I may experience the adverse mood reactions noted above. With long term use of cannabis, the effects on my attention, concentration and short term memory may worsen and can persist after I stop using cannabis.
7. I understand that some side effects of cannabis, such as drowsiness, sedation and dizziness, are made worse when cannabis is used with sleeping medication, tranquilizers, pain medications, antihistamines and seizure medications to name a few. I understand it is my responsibility to inform my physician of any and all side effects I have with this medication.
8. I understand that if I am pregnant or become pregnant while taking cannabis, my baby may develop behavioral and attention problems as a result of prenatal exposure to cannabis, as well as other unknown complications. There may be an increased risk of sudden infant death syndrome in babies born to mothers using cannabis in pregnancy. I agree to advise my physician if there is a possibility that I am or might be pregnant.

Patient Certification

9. I understand that I must have a valid New York State Medical Cannabis patient registration card in order to purchase and use medical cannabis products.
10. I agree to provide my doctor with a complete and accurate medical history, including my past medical treatment, the identity of all other providers from whom I receive medical treatment, any medications I am currently taking (including over the counter drugs, herbal supplements, vitamins, etc.), and any history of alcohol or drug addiction or dependency. I

agree to tell my physician if any new medications are prescribed to me by any other physician and if any doses of my current medications are changed by another physician.

11. I agree to take cannabis as prescribed by my physician and not to change the amount or frequency of my cannabis use without first discussing it with my physician. I will not share or sell any controlled substances, including cannabis, with or to anyone else under any circumstances, even those persons who may also possess a valid New York State Medical Cannabis patient registration card.
12. Significantly elevating doses without permission or losing any cannabis may be viewed as signs of misuse and may be reasons for my physician to discontinue my patient certification.
13. I agree that only Dr. _____ will certify me for cannabis. My cannabis can only be prescribed for me by Dr. _____. I agree not to seek certification for cannabis from any other physician or other person.
14. I agree to tell any other physician who might treat me that I take cannabis for medical reasons.
15. I agree I will not drink alcohol or take other mood altering drugs (tranquilizers, sleeping pills, other mood stabilizers) unless prescribed to me by a physician. I understand that using cannabis with other drugs may lead to an overdose.
16. I will not use any illegal controlled substances, including but not limited to cocaine, heroin, or other similar substances.
17. If cannabis causes me to become drowsy, sedated or dizzy, I understand I must not drive a motor vehicle (including all terrain vehicles, snowmobiles, boats) or operate machinery that could put my life or someone else's life at risk. If I do drive while using cannabis, I understand can be charged with Impaired Driving. If I am charged with impaired driving, while using cannabis, I agree that Dr. _____ is not to blame and will not be named by me in any resulting legal action. I accept full responsibility for any and all risks associated with the use of cannabis.
18. I agree that I will not alter any of my prescriptions or my certification card. I understand that if I do so, I will immediately be discharged from the practice.
19. I agree to safeguard my cannabis from loss, theft or damage. I understand that if my cannabis is lost, stolen or damaged, I will report it immediately and file a police report. I agree not to use cannabis in any unintended manner.
20. I agree to dispose of unused/unwanted cannabis products under the direct supervision of my physician or dispensary pharmacist.
21. I agree to participate actively in any additional therapies my doctor recommends. If my doctor determines that I have become dependent on controlled substances, I agree to participate in a program for chemical dependency.
22. I agree to submit to a blood or urine test whenever requested by my doctor. If the results reveal that I have failed to comply with this agreement and my treatment plan, I understand that my doctor may elect to decrease or discontinue my patient certification. I understand that if I refuse to undergo drug testing, I may be terminated from the practice.
23. I authorize my doctor and his office staff to communicate with my treatment providers and pharmacies regarding my compliance with this agreement.

24. I further authorize my physician to cooperate fully with any city, county, state or federal law enforcement agencies, the New York State Board of Pharmacy, the Bureau of Controlled Substances, and the federal Drug Enforcement Agency in the investigation of any possible misuse, sale, or diversion of my cannabis. I authorize my doctor to provide a copy of this agreement to any of these agencies and to any pharmacy. I understand that I waive any applicable privilege, right of privacy or confidentiality concerning requests for my protected health information from these entities.

25. I understand that my compliance with the terms of this agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor's treatment will be based on this agreement. Failure to comply with all of the conditions in this agreement may result in

    a. Danger to my life and health, or the life and health of others.
    b. My doctor electing to discontinue my patient certification to use medical cannabis. If this occurs, my doctor may choose to taper cannabis to avoid withdrawal symptoms.
    c. Discharge from my doctor's practice.

Patient Certification Termination

26. I understand there is a risk of becoming addicted to cannabis. This means I might become psychologically dependent on cannabis, using it to alter my mood or "get high". I may be unable to control my use of it. People with a past history of alcohol or drug problems are more susceptible to addiction. If this occurs, **my cannabis certification will be discontinued** and I will be referred to a drug treatment program for help with this problem.

27. I understand that inappropriate behavior or threats toward my physician, the staff or other patients are not allowed. If this happens, my physician may discontinue my patient certification to use medical cannabis. In addition, **my physician may decide to stop providing me with medical care altogether.**

28. If I violate this agreement, I understand that my physician may discontinue my patient certification to use medical cannabis. In addition, **my physician may decide to stop providing me with medical care altogether**.

29. The terms and conditions of this agreement have been fully explained to me. All of my questions and concerns regarding both my treatment and this agreement have been answered to my satisfaction. I have been given a copy of this document.

This Agreement is entered into on _____

Patient signature: _____

Physician signature: _____

Witnessed by: _____