**Cannabis Doctors of Florida**

1065 NE 125th Street, Suite 300; North Miami, FL 33161

305-893-3989 ● www.cannabisdocsfl.com

**PATIENT INFORMATION**

First Name: ____________________ Middle Initial: __________________ Last Name: ____________________

Primary Phone: _________________________ Email: ____________________________________________

Date of Birth: ________________ SSN: _______________________ Weight: _______lbs.
mm/dd/yyyy

Stree Address: ___________________________________________________________________________________

City: _________________________ State: ____ Zip Code: __________

**QUALIFYING CONDITIONS**

- ☐ Cancer
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Crohn's disease
- ☐ HIV
- ☐ AIDS
- ☐ Parkinson's Disease
- ☐ ALS
- ☐ PTSD
- ☐ Chronic nonmalignant pain

☐ OTHER debilitating condition(s) of the same kind or class as comparable to those listed, and for which a physician believes that the medical use of marijuana would likely outweigh the potential health risks for a patient.

Please indicate other condition(s): ____________________________________________________________________

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## MEDICAL MARIJUANA INFORMED CONSENT

I am being evaluated for a physician's recommendation for medicinal use of marijuana. The physician will make this recommendation based, in part, on the medical information I have provided. I have not misrepresented my medical condition in order to obtain this recommendation and it is my intent to use marijuana only as needed for the treatment of my medical condition, nor for recreational or non medical purposes. I understand that it is my responsibility to be informed regarding state and federal laws regarding possession, use, sale/purchase, and/or distribution of marijuana. I have been informed of and understand the following:

I understand that possession or use of medical marijuana is unlawful under Federal law and outside of the state of Florida. I also understand that possession or use of medical marijuana is unlawful within the state of Florida if not recommended for medical purposes by a licensed medical doctor with the legal ability to do so.

Certain forms of medical marijuana may have intoxicating effects and has not been analyzed or approved by the United States Food and Drug Administration (FDA). Marijuana for medical use is not subject to any standards, quality control, or other oversight for health, safety, or efficacy. Medical marijuana may contain unknown quantities of active ingredients, impurities, or contaminants.

The use of medical marijuana may affect coordination, cognition, and judgment. While under the influence of medical marijuana, do not to drive, operate machinery, or engage in potentially hazardous activities.

I understand side effects of medical marijuana can include but are not limited to: Memory loss, Irregular heartbeat, Slower reaction time/inability to concentrate, Poor physical condition, Cough/bronchitis/shortness of breath, Dizziness, Impaired vision, Drowsiness/fatigue/ abnormal sleep, Depression, Laryngitis, Low blood pressure, Impairment of motor skills, Anxiety/Nervousness, Dry mouth, Suppression of immune system, Hunger/Loss of appetite, Dependency, Confusion, Feelings of euphoria, Headache/nausea/vomiting, Numbness, Agitation, Paranoia/psychotic symptoms, Sedation.

The scientific basis for the medical use of medical marijuana is not complete. There is little known regarding how medical marijuana may, or may not, react with other pharmaceutical or herbal medications.

Some patients can become dependent on medical marijuana. This means they experience withdrawal symptoms when they stop using medical marijuana. Signs of withdrawal symptoms can include feelings of depression, sadness or irritability, restlessness or mild agitation, insomnia, sleep disturbance, unusual tiredness, trouble concentrating, and loss of appetite.

Women should not consume medical marijuana while planning to become pregnant, during pregnancy, or while breast feeding, except on the advice of the certifying health practitioner, and in the case of breast feeding mothers, on the advice or the infant's pediatrician.

**Patient's (or legal guardian's) Signature: ________________________________________Date: ______________**

**Printed Name: ________________________________________**

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## MEDICAL MARIJUANA PATIENT AGREEMENT

I am over 18 years of age and understand the requirements of the State of Florida's medical marijuana program.

I have agreed to and have paid the non-refundable $99 initial evaluation fee.

I agree to schedule a follow-up appointment at least once every six (6) months in order to continue to receive medical marijuana recommendations.

I have been advised of the current state of knowledge in the medical community of the effectiveness of medical marijuana for the treatment of my condition.

I have been advised of the potential risks and side effects of using medical marijuana.

I have read and understand the Medical Marijuana Informed Consent and I have initialed next to each to acknowledge this understanding.

In the event that I experience an adverse reaction to medical marijuana, I am advised to contact my medical professional. In the event my medical professional is not available, I agree to call 911 for help.

I am not pregnant, intending on becoming pregnant, or breastfeeding.

I understand that my medical professional does not condone that I cease treatment of medications that stabilize my mental or physical condition.

I understand if I give dishonest or untruthful information, the recommendation for medical marijuana may no longer be valid. I agree to promptly provide additional information in the event of any inaccuracies or misstatements in the information I have provided.

## AUTHORIZATION FOR TREATMENT

I hereby authorize treatment by Cannabis Doctors of Florida and have agreed to voluntarily receive such treatment. I consent to treatment and services deemed advisable by Cannabis Doctors of Florida. I acknowledge that any questions I have regarding this treatment may be directed towards Cannabis Doctors of Florida or staff.

## RELEASE OF LIABILITY

I agree that Cannabis Doctors of Florida and employees shall not be held responsible for any harm resulting to me and/or any other individuals because of my medical marijuana use.

I certify that I fully understand the potential risks and side effects related to the use of medical marijuana as described above.

In using medical marijuana, I fully accept responsibility and assume the risks and side effects associated with its use.

**Patient's (or legal guardian's) Signature:** ________________________________________ **Date:** ______________

**Printed Name:** ________________________________________