Patient information

FIRST NAME: ______________________MIDDLE NAME: _____________LAST NAME: _____________

DATE OF BIRTH: SEX: F M others: ________________

Contact information Mobile Phone:

Address: __________________ city_________ state ___ Zip: _____________.

EMAIL: _______________________

Consent for text and message voice: yes, No

NEXT OF KIN NAME or Emergency contact information

RELATION TO PATIENT: _______ Name First: last name:

Cell:

Please list the name of the Hospice you are under care:

____

Hospice Fax Number: ____

You can email your medical records to doc@chermd.com (less 5 pages)

Caregiver Acknowledgement/Consent/Disclosure

Caregiver Information:

Name: ________________________ Relation to Patient:____________

Driver's License #:______________ Phone Number:_______________

I agree to act as caregiver for __________________, who is a qualifying patient for Louisiana medical marijuana recommendation.

I agree to only possess and distribute medical cannabis for the purposes of assisting the patient.

I have been informed of and understand that:

I must prevent children and adolescents from gaining access to medicinal cannabis because of potential harm to their well-being. I will store cannabis in locked cabinets to prevent anyone else from using it.

• I cannot consume, by any means, any medical cannabis that has been dispensed on behalf of the qualifying patient.

• Selling, providing, diverting, or transferring by any means medical cannabis to any person other that the qualifying patient for whom I serve as a designated caregiver is a felony punishable by Louisiana state law.

• Intentionally making a false statement to a law enforcement official about any fact or circumstance relating to the medical use of cannabis to avoid arrest or prosecution is a misdemeanor punishable by Louisiana state law; and if convicted I will be disqualified from further participation as a designated caregiver.

I will report any suspected serious health effects in the qualifying patient caused by medical cannabis by informing my physician or, should the effects be suspected as life threatening, bring the qualifying patient to the emergency room.

I acknowledge the information listed above and certify the information provided in this application is true and accurate to the best of my knowledge.

Care giver signature: ____________________________ **Date:**______________

General Consent for Treatment (HIPPA)

We appreciate you entrusting your or a family members health care to our practice. However, we need your permission for our clinicians to examine you, provide treatments, and perform diagnostic studies as necessary. If more invasive procedures are deemed necessary, the risks and benefits of those invasive treatments will be explained to you. I give general consent to be treated practitioner of Cher Aymond MD Privacy Policy HIPPA Federal regulations require health practices to keep your medical information protected. Protected Health Information (PHI), is shared with affiliate healthcare practitioners, as well as healthcare providers that participate in your care, your insurance company to obtain payment for health benefits claims filed, or management of health issues relating to your health. All associates assisting with our internal operations are required to maintain confidentiality of protect health information. All other releases of information have to be specifically authorized by you. If you ask us to account for these release of information, we will provide that to you. You may also request and receive a copy of your medical record and ask questions about its content. We will keep your record as long as you are a patient of the practice and seven years after your last visit. You will be given a form to sign which shows the details of to whom you wish to have your PHI (Protected Health Information) released. I acknowledge that I have been informed about the privacy of my medical record.

INFORMED CONSENT

I am being evaluated for a physician's recommendation for medical 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 it only as needed for treatment of my medical condition, not for recreational or non-medical purpose. I understand that it is my responsibility to be informed regarding state and federal laws regarding the possession, use, sale/purchase and/or distribution of marijuana.

I have been informed of and understand the following

1. The federal government has classified marijuana as a Schedule 1 controlled substance. Schedule 1 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; (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 California, which have modified their state laws to treat marijuana as a medicine.
2.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 standards, quality control, or other oversight. Marijuana may contain unknown quantities of active ingredients (i.e., can vary in potency) impurities, contaminants, and substances in addition to THC, which is the primary psychoactive chemical component of marijuana.

3.Potential side effects from the use of marijuana include, but are not limited to, the following: dizziness, anxiety, confusion, sedation, low blood pressure, euphoria, difficulty in completing complex tasks, suppression of the body's immune system, inability to concentrate, impaired motor skins, paranoia, psychotic symptoms, general apathy, depression and/or restlessness. Dr Cher Aymond recommends cannabis use for the relief of serious symptoms only

4. I agree to contact Dr Cher Aymond from 8 to 5 during the week if I experience any of side effects listed above, or if I go to the ER, if I become psychotic, have suicidal thoughts.

5. The risk, benefits and drug interactions of marijuana are not fully understanding. If I am taking medication or undergoing treatment for any medical condition, I understand that I should consult with my treating physician(s) before using marijuana and that I should not discontinue any medication or treatment previously prescribed unless advised to do so by the treating physician(s).

6.Symptoms of marijuana overdose include, but not limited to, nausea, vomiting, hacking cough, disturbances in heart rhythms, numbness in the hands, feet, arms, or legs, anxiety attacks and incapacitation. If I experience these symptoms, I agree to contact Cher Aymond MD immediately or go to the nearest emergency room.

7. I have the opportunity to discuss these matters with the physician and to ask questions regarding anything I may not understand or that I believe needed to be clarified. I acknowledge that Cher Aymond MD has informed me to the nature of a recommended treatment, including but not limited to, any recommendation regarding medical marijuana.

Release of Liability

I affirm that I have a serious medical condition. I have found or am interested in finding out whether or not medical marijuana provides symptoms relief. In requesting approval or recommendation for the use of medical marijuana, I assume full responsibility for any and all risks involved in this action. I assume full responsibility for any harm resulting to me and/or other individuals as a result of my use of cannabis. I, the undersigned, hereby request a consultation by the physician for purposes of determining the appropriateness of medical marijuana treatment. I acknowledge that using cannabis as medicine has been explained to me and that any questions that I have asked have been answered to my complete satisfaction. The physician, staff, and representatives are addressing specific aspects of my medical care, and unless otherwise stated are in no way establishing themselves as primary care provider. Should an approval be made for my medicinal use marijuana, I understand that there is a renewal date specified by the physician depending on the condition. I understand that it is my responsibility to see the physical to assess the possible continuance of cannabis use beyond the term of the approval. Furthermore, the undersigned, or anyone action on my behalf, hold the physician and his/her principals, agents, and employees, free of an harmless from any liability resulting from the use of medical marijuana.

Patient Signature

_______________________________________ Date ______________________ Legal Guardian signature:_______