**Bucyrus Internal Medicine, Inc.**

**Medical Marijuana Acknowledgement of Disclosure and Informed Consent**

Please read each item below and initial in the space provided to indicate that you understand and agree with the information regarding the risks and side effects of using Medical Marijuana. Do not sign this agreement and do not use Medical Marijuana if you have questions about or do not understand the information you have received. Please tell us if you do not understand any of the information provided.

Patient's Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_/\_\_\_\_/\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State Ohio Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Obtaining Consent: **Dr. Roy W. Harris, DO, FACOI** .

Bucyrus Internal Medicine, Inc.

510 Hill Street Bucyrus, OH 44820

Phone 419-562-9834

**ATTENTION:**

I am being evaluated for a physician's recommendation for Medical Marijuana. The physician will make this recommendation based, in part, on the medical information I have provided. I hereby acknowledge that I have not misrepresented my medical condition to obtain this recommendation and it is my intent to use Medical Marijuana only as needed for the treatment of my medical condition, not for recreational or non- medical purposes. 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 Medical Marijuana. I have been informed of and understand the following:

1. I understand that possession or use of Medical Marijuana is unlawful under Federal law and outside of

the state of Ohio. I also understand that possession or use of Medical Marijuana is unlawful within the

state of Ohio if not recommended for medical purposes by a licensed medical doctor with the legal

ability to do so. \_\_\_\_\_\_\_\_\_\_\_\_\_initial

2. Certain forms of Medical Marijuana may have intoxicating effects and has not been analyzed or

approved by the United States Food and Drug Administration and was produced without FDA

oversight for health, safety, or efficacy. Medical Marijuana may contain unknown quantities of active

ingredients, impurities, or contaminants. \_\_\_\_\_\_\_\_\_\_\_\_\_initial

3. A physician-patient relationship shall be established and maintained for the provision of medical

service for the recommendation of Medical Marijuana by an in person visit and documentation

maintained in a medical record concerning all visits. Medical records shall be retained per state law

guidelines at Bucyrus Internal Medicine, Inc. \_\_\_\_\_\_\_\_\_\_\_\_\_initial

4. The efficacy and potency of Medical Marijuana may vary widely depending on the strain and ingestion

method. \_\_\_\_\_\_\_\_\_\_\_\_\_initial

5. If Medical Marijuana is vaporized: Such use may be hazardous to your health. Medical Marijuana

contains carcinogens and can lead to an increased risk for cancer, tachycardia, hypertension, heart

attack, birth defects, brain damage, and lung disease. \_\_\_\_\_\_\_\_\_\_\_\_\_initial

6. If Medical Marijuana is eaten or swallowed: This product has been infused with cannabis or active

compounds of cannabis. When eaten, or swallowed, the intoxicating effects of this drug may be

delayed by two or three hours or more. \_\_\_\_\_\_\_\_\_\_\_\_\_initial

7. There is limited information on the side effects of using Medical Marijuana, and there may be

associated health risks. \_\_\_\_\_\_\_\_\_\_\_\_\_initial

8. For some patients, chronic Medical Marijuana usage can lead to laryngitis, bronchitis, and general

apathy (lack of interest or inability to feel normal). \_\_\_\_\_\_\_\_\_\_\_\_\_initial

9. I have been further advised that some forms of Medical Marijuana may contain chemicals known as

tars that may be harmful to my health. \_\_\_\_\_\_\_\_\_\_\_\_\_initial

10. 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.

\_\_\_\_\_\_\_\_\_\_\_\_\_initial

11. 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. \_\_\_\_\_\_\_\_\_\_\_\_\_initial

12. 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. \_\_\_\_\_\_\_\_\_\_\_\_\_initial

13. Some users develop a tolerance/ dependence to Medical Marijuana. This means higher and higher

doses are required to achieve the same symptom relief. I may be developing a dependency on

marijuana, I should contact my primary care physician. \_\_\_\_\_\_\_\_\_\_\_\_\_initial

14. The possibility exists that Medical Marijuana may exacerbate schizophrenia in persons predisposed

to that disorder. \_\_\_\_\_\_\_\_\_\_\_\_\_initial

15. Women should not consume Medical Marijuana while planning to become pregnant, during

pregnancy, or while breast feeding. In the case of breast feeding mothers, on the advice of the

infant’s pediatrician. \_\_\_\_\_\_\_\_\_\_\_\_\_initial

16. Using Medical Marijuana while under the influence of alcohol is not recommended because

additional side effects may become present. \_\_\_\_\_\_\_\_initial

17. 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 that if I drive while under the influence of marijuana, I can be

arrested for "driving under the influence."\_\_\_\_\_\_\_\_\_\_\_\_\_initial

18. Please note that Medical Marijuana will degrade over time. \_\_\_\_\_\_\_\_\_\_\_\_\_initial

19. I understand the importance of securely storing medical marijuana to reduce the risk of exposure to

children, pets, and others. I will not Share My Medical Marijuana with Others. \_\_\_\_\_\_\_\_\_\_\_initial

20. Medical marijuana shall not be possessed or administered at any public or private place where

medical marijuana is prohibited, including but not limited to workplace and federal property.

\_\_\_\_\_\_\_\_\_\_\_\_\_initial

21. Consequently, using or possessing marijuana and firearms at the same time is illegal, regardless of

whether the state has passed legislation authorizing marijuana use for medicinal purposes.

\_\_\_\_\_\_\_\_\_\_\_\_\_initial

**Medical Marijuana Patient Agreement**

1. I am over 18 years of age and understand the requirements of the State of Ohio’s Medical Marijuana

Program. If under 18 years, have signed a minor consent form obtained by patient's parent or legal

representative. \_\_\_\_\_\_initial

2. 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. \_\_\_\_\_\_\_\_\_\_\_\_\_initial

3. I understand and have been advised of the potential side effects which may occur while I am taking

Medical Marijuana. \_\_\_\_\_\_\_\_\_\_\_\_\_initial

4. Symptoms of Medical Marijuana overdose include but are not limited to nausea, vomiting, hacking

cough and disturbances to heart rhythm, numbness in the hands, feet, arms or legs, anxiety attacks

and incapacitation. If I experience these symptoms, I agree to go to nearest Emergency Room.

\_\_\_\_\_\_\_\_\_\_\_\_\_initial

5. In the event that I experience an side effects listed above, or I become depressed or psychotic, have

suicidal thought, or experience crying spells, experience respiratory problems, changes in my normal

sleeping patterns, extreme fatigue, increased irritability, or begin to withdraw from my family and/or

friends, I am advised to contact my primary care physician. In the event my primary care physician is

not available, I agree to call 911 for help and I am advised to lie down, relax, and rest until help

arrives. \_\_\_\_\_\_\_\_\_\_\_\_\_initial

6. I have never had symptoms of schizophrenia or have been diagnosed as having schizophrenia by a

physician or mental health professional. \_\_\_\_\_\_\_\_\_\_\_\_\_initial

7. I have no direct blood relatives (father, mother, siblings) that have had symptoms or has been

diagnosed as having schizophrenia or has been psychotic. \_\_\_\_\_\_\_\_\_\_\_\_\_initial

8. I agree to tell my medical professional if I have ever had symptoms of schizophrenia, been psychotic

or attempted suicide. I also agree to tell Dr. Harris, if I have ever been prescribed or

taken medicine for any of these problems. \_\_\_\_\_\_\_\_\_\_\_\_\_initial

9. I am not pregnant, intending on becoming pregnant, or breastfeeding. \_\_\_\_\_\_\_\_\_\_\_\_\_initial

10. When under the influence and/or in possession of Medical Marijuana in public, your state issued

Medical Marijuana ID Card or temporary state issued verification should be on your person at all

times. \_\_\_\_\_\_\_\_\_\_\_\_\_initial

11. I understand I must give 48-hours’ notice for cancellation of appointments. I further understand that 2

or more no calls/no shows within a calendar year will result in my discharge from the practice as well

as revocation of Dr. Harris's patient recommendation for Medical Marijuana. \_\_\_\_\_\_\_\_\_\_\_\_\_initial

12. I understand there are certain requirements to remain in compliance with Ohio law regarding Medical

Marijuana and may be updated at times. I will remain updated between visits by staying current with

these changes. (Ohio Official Resource: Medical Marijuana Control Program) \_\_\_\_\_\_\_\_\_\_\_initial

13. I understand that the Ohio Board of Pharmacy may revoke my Medical Marijuana Card for any of the

following:

(a) The patient or legal representative makes material misrepresentations in his or her application.

(b) The patient uses his or her card to obtain cannabis for another individual

(c )The legal representative purchases, obtains, possesses, or uses cannabis not sold by an approved

dispensing organization, or

(d) The patient is no longer a qualified patient.

(e) I am not in compliance with Ohio state law and regulations set forth (Ohio Official Resource:

Medical Marijuana Control Program) \_\_\_\_\_\_\_\_\_\_\_\_initial

**14. I understand if I give dishonest or untruthful information, I will be discharged. If Dr. Harris**

**learns that the information furnished is false or misleading, the recommendation for 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.** \_\_\_\_\_\_\_\_initial

15. Dr. Roy Harris requires that I return for a Follow Up in 90 days after my initial appointment

to review my medical condition and to evaluate my use of Medical Marijuana. Further Follow Ups

make be scheduled at intervals of 3 months to 6 months. I will make sure to schedule my 90 day

Follow Up before I leave Appointment. \_\_\_\_\_\_\_\_\_\_\_\_initial

16. I have been advised about other medically acceptable alternatives for my qualifying medical

condition that do not involve the recommendation of medical marijuana. \_\_\_\_\_\_\_\_\_\_\_\_initial

17. I agree to continue regular medical FOLLOW-UP at my personal primary care physician's office. I

understand that interaction with healthcare providers is in the best interest for my quality of care.

**THIS IS VERY IMPORTANT**. \_\_\_\_\_\_\_\_\_\_\_\_initial

18. I understand that it is important to my health to be aware of the use of Medical Marijuana and have

been given access to Bucyrus Internal Medicine, Inc. website (www.bucyrusim.com) to review

education material. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_initial

**Release of Liability**

1. I hereby acknowledge Bucyrus Internal Medicine, Inc, and its employees are not addressing specific

aspects of my medical care, but are evaluating my qualifying medical condition and medical history

for recommendation for medical marijuana. I will continue to see my primary care provider for care

for all my medical conditions. Furthermore, I, for myself, my heirs, assigns, or anyone acting on my

behalf, hold Bucyrus Internal Medicine, Inc., and its principals, agents, and employees free of and

harmless from any responsibility for any harm resulting to me and/or other individuals because of my

Medical Marijuana use. \_\_\_\_\_\_\_\_\_\_\_\_\_initial

2. I certify that I fully understand the potential risks and side effects related to the use of Medical

Marijuana as described above and had the opportunity to discuss these matters with Dr. Roy Harris and

to ask questions regarding anything I may not understand or that I need clarified. \_\_\_\_\_\_\_\_\_\_\_initial

3. In using Medical Marijuana, I fully accept responsibility and assume the risks and side effects

associated with its use. Dr. Harris informed me of the risks, complications, and expected benefits of

treatment pertaining to my qualifying medical condition and medical history, including its likelihood

of success and failure. \_\_\_\_\_\_\_\_\_\_\_\_\_initial

4. I agree that Bucyrus Internal Medicine, Inc., and employees shall not be held responsible or liable for

any harm resulting to me and/or any other individual(s) because of my use of Medical Marijuana.

\_\_\_\_\_\_\_\_\_\_\_\_\_initial

5. I certify that I have read this document and declare under penalties of perjury that the information

contained herein is true, correct, and complete. I have initialed next to each to acknowledge this

understanding. All Forms completed by me concerning my visit(s) are accurate and truthful.

\_\_\_\_\_\_\_\_\_\_\_\_\_initial

Patient’s (or legal guardian’s) Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

Printed Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_/\_\_\_\_/\_\_\_\_