SNA MEDICAL PC

1711 Sheepshead Bay Rd Brooklyn, NY 11235 718-615-0014

Acknowledgements, Agreements, Disclosures and Informed Consent

Please read each item below and initial in the space provided to indicate that you understand and agree to each item. By initialing, you understand and agree to the information disclosed. If you have questions or do not understand the information below, consult with the attending physician before initializing or signing this agreement. Please do not sign this agreement and do not use marijuana if you do not understand the information you have received.

I, _____, (Patient's Name), understand that medical marijuana is a medicine used in treating the suffering caused by serious and debilitating medical conditions. Serious and debilitating medical conditions include: Cancer, HIV, Nausea, Chronic Pain, Glaucoma, Cachexia, Seizures and persistent muscle spasms. Additionally, medical marijuana is used in the treatment of other chronic or persistent medical symptoms that:

- Substantially limits the ability of the person to conduct one or more major life activities as defined in the Americans with Disabilities Act of 1990 (Public Law 101-336)
- Other conditions for which marijuana provides relief
- If not alleviated, may cause harm to the patient's safety or physical or mental health

Patient agrees by initialing the following:

_____ I have been advised that the use of medical marijuana may affect my coordination, motor skills and cognition in ways that could impair my ability to drive and agree not to operate heavy machinery, drive or engage in potentially hazardous activities.

_____ I understand that side effects may occur while I am taking medical marijuana. Side effects of medical marijuana can include but are not limited to: Euphoria, difficulty in completing complex tasks, low blood pressure, sedation, dysphoria, alterations in the perception of time and space, dizziness, anxiety, confusion, impairment to short term memory, inability to concentrate, suppression of the body's immune system, increased talkativeness, impairment of motor skills, delayed reaction time, loss of physical coordination, paranoia psychotic symptoms and overeating.

_____I understand that some patients become dependent on marijuana. This means they experience withdrawal symptoms when they stop using marijuana. Signs of withdrawal symptoms can include: Feelings of depression, sadness, irritability, insomnia, restlessness, agitation, loss of appetite, trouble concentrating, sleep disturbances and unusual tiredness.

_____I understand that chronic use of medical marijuana can lead to laryngitis, bronchitis and general apathy.

_____ I understand that although marijuana does not produce a specific psychosis, the possibilities exists that is may exacerbate schizophrenia in persons predisposed to that disorder.

_____ I agree to tell the attending physician if I have ever had symptoms of depression, been psychotic, attempted suicide or had any other mental problems. I also agree to tell the attending physician if I have ever been prescribed or taken medicine for any of the conditions stated above. Furthermore, I understand that the attending physician does not suggest nor condone that I cease treatment and or medication that stabilize my mental or physical condition.

_____I understand there are few known interactions between marijuana and medications other than herbs. However, very few interactions between herbs and medications have been studied. I agree to tell my attending physician if I am using any herbs, supplements or other medications.

_____ I am aware that a Notice of Compliance has not been issued under the Food and Drug Regulations concerning the safety and effectiveness of Marijuana as a drug. I understand the significance of this fact.

_____I am aware that medical marijuana has not been approved under Federal Regulations and I understand that medical marijuana has not been deemed legal under federal law.

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_____I understand some users might develop a tolerance to marijuana. This means higher and higher doses are required to achieve the same benefit. It is recommended for patients to have an intermission with the drug for at least 3 weeks every 3-4 months. If I think I may be developing a tolerance to marijuana, I will notify the attending physician.

_____ I understand the benefits and risks associated with the use of marijuana are not fully understood and that the use of marijuana may involve risks that have not been identified. I accept such risk.

_____I understand should respiratory problems or other ill effects be experienced in association with the use of medical marijuana, I agree to discontinue its use and report any such problems or effects to the attending physician. Although smoking marijuana has not been linked to lung cancer, smoking marijuana can cause respiratory harm, such as bronchitis. Many researchers agree that marijuana smoke contains known carcinogens (chemicals that can cause cancer) and that smoking marijuana may increase the risk of respiratory diseases and cancers in the lungs, mouth and tongue. I have been advised that medical marijuana smoke contain chemicals known as tars that may be harmful to my health. I understand that there are many methods of intake that substantially reduce the harmful effects of smoking such as vaporizers, edibles, drops, etc.

_____I understand Marijuana varies in potency. The effects of marijuana can also vary with the delivery system. Estimating the proper marijuana dosage is very important. Symptoms of marijuana overdose include, but are not limited to nausea, vomiting, hacking cough, disturbances to heart rhythms, numbness in the limbs, anxiety attacks and incapacitation.

_____If I start taking medical marijuana, I agree to tell my attending physician if I: Start to feel sad or have crying spells, lose interest in my normal activities, have changes in my normal sleeping patterns, become more irritable than usual, lose my appetite, become unusually tired, withdraw from family and friends, or any other side effect that is not to your liking.

_____I agree that if I am a female patient that I will contact my attending physician if I become or are thinking about becoming pregnant. I acknowledge that the use of medical marijuana creates pass-through problems to a fetus during pregnancy and to a baby during breastfeeding.

_____I understand that using marijuana while under the influence of alcohol is not recommended. Additional side effects may become present when using both alcohol and marijuana.

_____I should not be driving a vehicle while using marijuana and that I can get a DUI for driving under the influence.

_____Medical marijuana is not regulated by the USFDA and therefore may contain unknown quantities of active ingredients, impurities and or contaminants.

_____I am not permitted to smoke within 1,000 feet of any daycare or school. If I reside near those institutions, I must use my medicine within the privacy of my own home.

_____I agree to follow up with the attending physician at SNA MEDICAL PC with supporting medical records pertaining to my medical conditions.

_____ I understand the attending physician, staff and or representatives of SNA MEDICAL PC are neither providing, dispensing nor encouraging me to obtain medical marijuana. I also acknowledge that the attending physician, staff and or representatives of SNA MEDICAL PC will NOT be providing or discussing information regarding dispensary, co-op, delivery service or any other way to obtain marijuana.

_____I certify that I have read this document and declare under penalty of perjury that the information contained herein it true, correct and complete. I acknowledge that any manipulation, alteration or falsification of this form, the SNA MEDICAL PC letter of recommendation will result in the immediate termination of any legal right to my use of medical marijuana. Furthermore, SNA MEDICAL PC will report any of the above mentioned activities to the appropriate local authorities.

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_____The physician, staff and representatives of SNA MEDICAL PC are addressing specific aspects of my medical care and, unless otherwise stated, are in no way establishing themselves as my primary care physician/provider. Furthermore, the undersigned, my heirs, assigns, or anyone else acting on behalf, hold the physician and his/her principals, agents and employees, free of and harmless from any responsibility for any harm resulting to me and/or other individuals as a result of my medical marijuana use.

Patient Signature:_____ **Date:**_____

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RELEASE OF LIABILITY

I attest that the information on this form is correct and any medical history presented or discussed with the doctor is all factual and complete to the best of my knowledge. I do not plan or intend to use my Physician's recommendation for the purpose of illegally obtaining medical marijuana. Solely for verification purposes, I authorize SNA MEDICAL PC to converse of my medical condition.

I understand that I must be a New York State resident to obtain an approval or recommendation for the use of medical marijuana under the New York State Assembly Bill A06357E (Compassionate Care Act signed in to law by Governor Cuomo on July 4th, 2015.

I affirm that I have a serious medical condition that negatively affects my quality of life. I have found or am interested in finding out whether or not medical marijuana provides substantial relief and improvement in my condition.

I understand that the cannabis plant is not regulated by the United States Food and Drug Administration and therefore may contain unknown quantities of active ingredients, impurities and/or contaminants. I understand the potential risks associated with an elevated daily consumption of medical marijuana including risks with respect to the effect on my cardiovascular and pulmonary systems and psychomotor performance, risks associated with the long-term use of marijuana, as well as potential drug dependency. I am aware that the benefits and risks associated with the use of marijuana are not fully understood and that the use of marijuana may involve risks that have not been identified. In requesting an approval or recommendation for the use of medical marijuana, I assume full responsibility for any and all risks involved in this action.

I have been advised that medical marijuana smoke contains chemicals known as tars that may be harmful to my health. Recent research indicates that vaporizing cannabis may eliminate exposure to tar. Should respiratory problems or other ill effects be experienced in association with its use, it should be discontinued and reported to the physician immediately.

I was also advised that the use of medical marijuana may affect my coordination and cognition in ways that could impair my ability to drive, operate machinery, or engage in potentially hazardous activities. I assume full responsibility for any harm resulting to me and/or other individuals as a result of my use of cannabis.

New York State Assembly Bill A06357E (Compassionate Care Act), provides for the possession for the personal medical purposes of the patient with a physician approval or recommendation. It should be made clear that the physician, staff and representatives of this practice are not providing medical marijuana, nor are they encouraging any illegal activity in my obtaining medical marijuana.

I, the undersigned, hereby request a consultation by the physician for purposes of determining the appropriateness of medicinal marijuana treatment. I acknowledge that using cannabis as a 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 of 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 physician to assess the possible continuance of cannabis use beyond the term of the approval.

Furthermore, the undersigned, or anyone acting on my behalf, hold the physician and his/her principals, agents, and employees, free of and harmless from any liability resulting from the use of medical marijuana.

I further understand that by signing below, I am authorizing the release of any part of this record, except for identifying information, for use in data analysis of medical marijuana treated patients.

Patient Signature:_____ **Date:**_____

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Medical History Form

NAME_____ **DOB**___/___/___ **TODAY'S DATE**_____

Address: _____City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____May we email you in the future: Y☐ / N☐

Emergency Contact:_____

MEDICAL HISTORY: What medical Conditions do you have? Select all that apply, or write in if not listed:

☐ Cancer (Specify)_____ ☐ Spinal cord disorder (Specify)_____
☐ Positive status for HIV or AIDS ☐ ALS ☐ Epilepsy
☐ Parkinson's disease ☐ Multiple Sclerosis ☐ Huntington's disease
☐ Inflammatory bowel disease (Specify)_____
☐ Neuropathies (Specify)_____
☐ Schizophrenia ☐ Depression ☐ Bipolar Disorder ☐ Anxiety
☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ High Cholesterol
☐ Kidney Disease ☐ Liver disease ☐ Lung Disease ☐ Asthma
☐ Anemia ☐ Acid Reflux ☐ Allergies ☐ Glaucoma

Others: 1. _____ 2. _____ 3. _____

SURGICAL & HOSPITALIZATION HISTORY

List all of surgeries or hospitalizations (with cause) you have had.

_____ _____

_____ _____

_____ _____

FAMILY HISTORY

Family Member	Year Born	Living? (Y /N)	Medical Conditions	Cause of Death (if deceased)	Age at Death
Mother					
Father					
Sister					
Sister					
Brother					
Brother					

SOCIAL

Please list people you currently live with:_____

Are you: ☐ Single ☐ Married ☐ Divorced ☐ Other?_____

Are you currently employed? YES☐ NO☐ What is your occupation?_____

Do you drive a car? YES☐ NO☐

How much do you smoke?_____ How many years?_____

How much alcohol (including beer) do you drink in week?_____

Have you used or currently use recreational drugs? YES☐ NO☐ If yes how long_____

Do you currently use marijuana? Yes / No (**if yes)** How often and what methods? _____

_____

_____

Do you currently use cocaine, methamphetamine, opiates, heroin or other street drugs? Yes / No

(**If yes, explain**) _____

_____

Have you been arrested or charged with a crime in the past two years? Yes / No

(**If yes**, please describe) _____

_____

_____

Are you currently on parole or probation? Yes / No (**if yes, please see clinic manager)**

Have you been evaluated for medical marijuana use by another physician in the past? Yes / No

(**If yes,** please give name of practice, doctor, date seen and condition for evaluation) _____

_____

Have you been denied a recommendation for medical marijuana use by another MD in the past? Yes / No

(**If yes,** please explain) _____

_____

Are you currently attending or have you attended any substance abuse or rehabilitation program? Yes/No

(**If yes,** please provide details)_____

_____

Do you ever have thoughts of suicide or have you ever attempted suicide? Yes / No

(**If yes,** please provide details)_____

_____

HEALTH MAINTENANCE

Please list the YEAR of your last screening test below: (Circle A, if abnormal)

PAP smear: _____/ A☐ Mammogram: _____/ A☐ Colonoscopy: _____/ A☐

DEXA(for osteoporosis)_____/ A☐ Eye Exam: _____/ A☐

Immunizations/vaccine- Please list the YEAR of your last:

Tetanus Shot: _____ Flu Shot: _____ Pnemovax (Pneumonia shot): _____ Hepatitis A_____
Hepatitis B: _____ Chicken Pox/Shingles: _____ TB Skin Test:_____

Women Only: Age of first menstrual cycle_____ Date of last period _____
Do you have a history of irregular menstrual cycles? Y☐ / N☐
Are you currently on birth control? Y☐ / N☐ If yes, what type / name?_____
Number of pregnancies? _____ # of live births?_____ # of Miscarriages?_____
Have you had an abnormal Pap result? Y☐ / N☐ If yes, when? (year)_____
How often do you self-breast exam? (circle one) Never☐ Rarely☐ Weekly☐ Monthly☐

Allergic reactions to medicine or foods: Please list the TYPE OF REACTION.

Medication / Food Allergy	Reaction

Medications currently taking (with dosage): / If you have your own list please just provide a copy.

Medication	Dosage	The time(s) of the day you take it

Vitamins or supplements currently taking:

_____ _____ _____

Please circle any of the following problems you have:
☐Sleeplessness / ☐Chest Pain / ☐Constipation / ☐Nausea / ☐Diarrhea / ☐Loss of Appetite /
☐Stomach Pain / ☐Depression / ☐Vomiting / ☐Anxiety / ☐Weight loss / ☐Rectal Pain /
☐Swollen Ankles / ☐Skin Rash / ☐Palpitations / ☐Headaches / ☐Chronic Pain / ☐Muscle Spasm /
☐Difficulty Swallowing / ☐Coughing / ☐Fever / ☐Heart Burn / ☐Seizures / ☐Eye Problems /
☐Blood in Bowels / Other **(Describe Below)**

_____

Patient Signature: _____ **Date:** _____