Patient Information Date_____

Name _____ Age _____ Date of Birth _____
Gender: ☐ Male ☐ Female Height _____ Weight _____ Occupation_____
Medical History
Have you been evaluated by another physician for medical marijuana? ☐ No ☐ Yes
If yes, list the name of the doctor and dates seen: _____
Current medical complaint: (list the medical conditions that you use, or would like to use medical marijuana to help; please include the year of onset of these symptoms) _____

_____
What proof of your medical condition did you bring with you today? _____
Medications: Please list or provide a copy of your medications (include prescription and over the counter)

_____

_____
What medications are you allergic to? _____
Primary Care Provider: Please give the name and number of your healthcare provider (this includes acupuncture, psychologist, chiropractor, etc.) Please also list the date you were last seen _____

_____
Please give details regarding any hospitalization or surgery you have had._____

_____
Are there any other health problems that occur with you or in your family? _____

Patient History
Have you been arrested or charged with a crime in the last 2 years? ☐ No (please give details below) ☐ Yes

_____
Are you currently enrolled in school? ☐ No ☐ high school ☐ college ☐ other _____
Are you currently involved in a court case or do you have one pending? No (please specify below) Yes

_____
Are you currently on parole or probation? ☐ No ☐ Yes
Do you have a probation officer? ☐ No ☐ Yes
Have you attended a drug substance or rehabilitation program in the last 3 years? ☐ No ☐ Yes
Have you attempted suicide in the last 5 years? ☐ No When?_____ ☐ Yes
Have you had thoughts of suicide in the last 5 years? ☐ No When?_____ ☐ Yes
Do you have children under age 18? ☐ No What ages? _____ ☐ Yes

(Females) Are you pregnant? ☐ No ☐ Yes
Are you planning a pregnancy? ☐ No ☐ Yes

Do you currently smoke tobacco? ☐ No ☐ Yes
How many cigarettes per day do you smoke? _____
Do you currently use marijuana? ☐ No ☐ Yes
How often do you use marijuana? ☐ Almost every day ☐ 1-2 times per week ☐ more than once a month
How do you use marijuana? ☐ Smoke ☐ eat ☐ vaporize ☐ other _____
How long have you been using marijuana? ☐ less than a year ☐ over a year ☐ over 5 years

Patient Signature_____

Medical Cannabis Patient Agreement

Please read each statement carefully and **put your initials on the line** to indicate that you agree and understand:

_____ I understand that using cannabis while under the influence of alcohol is not recommended. I should not be driving a vehicle while using cannabis and I understand that I can get a DUI for driving under the influence.

_____ Cannabis 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 cannabis within 1000 feet of a school or daycare.
If I reside near those institutions, I must use my medicine within the privacy of my own home.

_____ If I start taking medical cannabis I agree to inform Dr. Barnes if I start to feel sad or have crying spells, become unusually tired, withdraw from family and friends, become more irritable than usual or lose my appetite.

_____ Also, I will inform Dr. Barnes if I lose interest in my usual activities or have changes in my normal sleep patterns.

_____ Some patients may develop a tolerance to cannabis where it will take more medicine to achieve the same clinical effect. It is recommended that patients take a break from using cannabis for a period of three weeks, every 120 to 160 days.

_____ Smoking cannabis can cause respiratory conditions such as bronchitis. Many researchers agree that cannabis smoke contains known carcinogens (chemicals that can cause cancer) and that smoking cannabis may increase the risk of respiratory diseases and cancers of the mouth, tongue and lungs. Should respiratory problems or other ill effects be experienced in association with the use of medical cannabis, I agree to discontinue its use and report any such problems to my primary care provider and Dr. Barnes.

_____ Cannabis smoke contains numerous chemicals that may be harmful to my health. A cannabis vaporizer may substantially reduce many of the potentially harmful toxins that are present in cannabis smoke. Although many patients choose to smoke cannabis, it can be ingested in many other ways.These oral preparations avoid the throat and mouth irritation and risk for lung problems associated with smoking cannabis. Speak with Allison about additional resources regarding ingestion methods and safety.

_____ I agree to tell Roger Barnes MD if I have ever had symptoms of depression, been psychotic, attempted suicide or had any other mental health 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.**I understand that the attending physician does not suggest nor condone that I cease treatment and/or medication that is prescribed to stabilize my physical or mental condition.**

Patient Signature_____ **Physicians Initials** _____

Medical Cannabis Patient Acknowledgement of Disclosure and Informed Consent

Instructions: Read each item below and initial to indicate that you understand and agree to each item. If you have questions or do not understand this information, consult with Dr. Barnes. Please do not use medical cannabis or sign this agreement if you do not understand this information.

I, _____**(print name),** understand that medical cannabis is a medicine used in treating the suffering caused by serious and debilitating medical conditions. Serious and debilitating medical conditions include cancer, hiv, nausea, arthritis, glaucoma, chronic pain, migraines, cachexia, seizures, anorexia, and persistent muscle spasms. Additionally, medical cannabis is used in the treatment of the chronic or persistent medical symptoms that substantially limit the ability of the person to conduct one or more major life activities as defined in the Americans with Disabilities Act of 1990.

_____ The use of cannabis may affect your coordination and cognition in ways that could impair your ability to drive. You agree not to operate heavy machinery, drive or engage in potentially hazardous activities while under the influence of cannabis. Patients should wait a minimum of 6 hours after cannabis use before engaging in potentially dangerous activities.

_____ I understand that some patients can become dependent on cannabis. This means they may experience mild withdrawal symptoms when they stop using cannabis. Signs of withdrawal symptoms, while generally mild can include feelings of depression, sadness or irritability, insomnia, loss of appetite, restlessness or mild agitation, trouble concentrating, sleep disturbances and/or unusual tiredness.

_____ Cannabis varies in potency. The effects of cannabis can also vary with the delivery system. Estimating the proper cannabis dosage is extremely important. Nausea, hacking cough, disturbances to heart rhythms and numbness in the limbs are some of the many symptoms of cannabis overdose.

_____ Chronic cannabis smoking can lead to bronchitis, laryngitis, and general apathy in some patients.

_____ Although cannabis does not produce a specific psychosis, the possibility exists that it may exacerbate schizophrenia in patients predisposed to that condition.

_____ The cultivation, possession and use of cannabis, even for medical purposes is still currently illegal under federal law. Physicians licensed in California may discuss and approve the medical use of cannabis to patients suffering from a qualifying medical condition. Roger Barnes MD and the staff are neither dispensing nor providing or encouraging me to obtain medical cannabis. Doing so would be a violation of federal law. **Please do not ask the doctor where to obtain medical cannabis.** Please visit internet and front counter for additional literature.

Release of liability

_____ The physician and staff are addressing specific aspects of my medical care and are in no way establishing themselves as my primary care provider. **I agree to follow up Roger Barnes MD, with supporting updated medical records pertaining to my condition.** These documents can be brought in person, mailed, faxed or emailed. Our contact information will be provided to you at the end of your visit.

Patient Signature_____ **Physicians Initials** _____

Medical Cannabis Patient Declaration

_____ I hereby declare that I have truthfully and completely disclosed all information regarding my medical condition. I attest that I do not intend to use my medical recommendation for illegal purposes.

_____ I attest that I am not a member, employee or agent of any media or law enforcement agency. It is illegal to film or record in this office with a video camera, cell phone or any other recording device. This is a direct violation of HIPAA regulations and doctor/patient confidentiality.

_____ I am aware that my recommendation can be revoked at any time if I have misrepresented myself or my condition, my intentions or falsified any medical records to the physician.

_____ I hereby authorize Roger Barnes MD & Associates to discuss my medical condition for verification purposes only.

_____ I hereby acknowledge that I have read and understand the HIPAA - Notice of Privacy Practices and may obtain a copy at my request.

Release Authorization

I, _____, Date of birth, _____ hereby authorize
(print first and last name) **(print date of birth)**
Roger Barnes MD & associates to verify me as a patient for the period of time for which the recommendation has been issued.

_____ I give permission for my medical records and file to be reviewed by another physician working with Roger Barnes MD, if Roger Barnes MD needs a second opinion, is not available, off premise, or has moved or terminated his/her practice.

_____ I hereby authorize you to verify my status as a patient via the online or telephone patient verification system for the period of time for which the recommendation has been issued.

_____ Roger Barnes MD will be informing me of: the nature of a recommended treatment plan including, but not limited to, any recommendation regarding medical cannabis. The risks, complications, and expected benefits of any recommended treatment, including its likelihood of success and failure and any alternatives to the recommended treatment, including the alternative of no treatment, and their risks and benefits. Roger Barnes MD may request that I visit another physician or specialist to further substantiate my condition. I will be informed of all the above mentioned regardless of whether or not I qualify as a patient.

_____ I hereby authorize you to disclose and verify my patient status to a marijuana dispensary or co-op upon my request for the purpose of obtaining membership into the club.

_____ I hereby authorize you to disclose and verify my patient status to law enforcement should I be arrested or detained related to my possession or use of marijuana.

Patient Name (print) _____ **Patient Signature** _____

Patient Contact Information

_____ I must be a California resident to obtain an approval for the use of cannabis (medical marijuana).

Home Address: _____

City: _____ **State**: _____ **Zip Code**: _____

Cell Phone #: _____ **Alternate Telephone #:** _____

Email address: _____

How would you like to be reminded about the expiration of your letter of recommendation in one year?
Please check all that apply

☐ Discreet text message Phone Number for text: _____

☐ Discreet phone call Phone number for call: _____

☐ Email ☐ Check here if email is same as above
Email address: _____

****

Voluntary State ID Card Program Release Form

If you choose to, you may apply for a medical marijuana identification card in the county which you reside. This identification card serves as evidence that you are authorized to possess and use marijuana in California. This is a voluntary program and state law does not require you to obtain the identification card. This card is different from the card you receive from your doctor.

If you are planning on obtaining a voluntary county ID card from the health department in your county, please complete the following.

Authorization for Release of Information

The undersigned hereby authorizes Roger A. Barnes MD & Associates and its authorized agents to release medical information to the California Department of Public Health for the issuance of a medical marijuana identification card and registration in the state database of authorized identification card holders.
This authorization shall expire one year from the date set forth below.

Date: _____

Print Name: _____

Patient Signature: _____