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WELLNESS CT

Medical Cannabis 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 cannabis medicines. Do not sign this agreement and do not use medical cannabis if you have questions about or do not understand the information you have received. Please tell the pharmacist at Bluepoint Apothecary & Wellness if you do not understand any of the information provided.

Patient's Name ______________________ DOB ___/___/___

Address ______________________

City ______________________ CT Zip Code ______________________

DISCLOSURES

- ✓ The cannabis plant is not regulated by the United States Food and Drug Administration and therefore may contain unknown quantities of active ingredients, impurities or contaminants. ________
- ✓ The efficacy and potency of cannabis may vary widely depending on the cannabis strain and ingestion method. Estimating the proper cannabis dosage is very important. ________
- ✓ Smoking cannabis can cause respiratory harm, such as chronic 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 lungs, mouth and tongue. ________
- ✓ Vaporizers may substantially reduce many of the potentially harmful smoke toxins that are normally present in cannabis smoke. ________
- ✓ Side effects of medical cannabis can include, but are not limited to: ________

- Short term 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

- ✓ Symptoms of cannabis overdose include but are not limited to nausea, vomiting, disturbances to heart rhythm. ________
- ✓ For some patients, chronic cannabis usage can lead to laryngitis, bronchitis and general apathy. There is little known regarding how cannabis may, or may not, react with other pharmaceutical or herbal medications. ________
- ✓ Some patients can become dependent on cannabis. This means they experience withdrawal symptoms when they stop using cannabis. 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. ________
- ✓ Some users develop a tolerance to cannabis. This means higher and higher doses are required to achieve the same symptom relief. ________
- ✓ The possibility exists that cannabis may exacerbate schizophrenia in persons predisposed to that disorder. ________
- ✓ Using cannabis while under the influence of alcohol is not recommended. ________

- ✓ The use of cannabis may affect coordination and cognition in ways that would very likely impair an ability to drive, operate heavy machinery, or engage in potentially hazardous activities. ________

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Medical Cannabis Patient Agreement

✓ I have read and understand the foregoing disclosures and have initialed next to each to acknowledge this understanding.______
✓ I have been further advised that cannabis smoke contains chemicals known as tars that may be harmful to my health.______
✓ I understand that side effects may occur while I am taking cannabis medicines.______
✓ In the event of overdose, I am advised to contact my authorized prescriber. In the event the authorized prescriber is not available, I agree to call 911 for help and I am advised to lie down, relax, and rest until help arrives.______
✓ I agree to tell my prescribing physician if I have ever had symptoms of depression, been psychotic, attempted suicide or had any other mental problems. I also agree to tell my prescribing physician if I have ever been prescribed or taken medicine for any of these problems.______
✓ I understand that my attending or prescribing physician does not suggest nor condone that I cease treatment of medications that stabilize my mental or physical condition.______
✓ If I start taking medical cannabis, I agree to tell my prescribing physician if I (any one or more of the following): ______
- Start to feel sad or have crying spells
- Lose my appetite
- Become unusually tired
- Lose interest in my usual activities
- Have changes in my normal sleep patterns
- Become more irritable than usual
- Withdraw from family and friends

✓ 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 or effects to my prescribing physician.______
✓ I understand that Bluepoint Apothecary & Wellness and its employees are not encouraging me to obtain medical cannabis.______

Release of Liability

I hereby acknowledge Bluepoint Apothecary & Wellness and its employees are not addressing specific aspects of my medical care nor are any of them my primary care provider. Furthermore, I, for myself, my heirs, assigns, or anyone acting on my behalf, hold Bluepoint Apothecary & Wellness and its 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 cannabis use.______

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

In using cannabis for medicinal use, I fully accept responsibility and assume the risks and side effects associated with its use.______

I agree that Bluepoint Apothecary & Wellness and employees shall not be held responsible for any harm resulting to me and/or any other individual(s) as a result of my medicinal usage of cannabis.______

I certify that I have read this document and declare under penalties of perjury that the information contained herein is true correct and complete.

Patient's Signature ______________________ Date ______________

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Addendum

Possession or use of this product is unlawful outside of the State of Connecticut. ______

If cannabis 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.
______

FOR FEMALE PATIENTS

Women should not consume cannabis products 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 of the infant's pediatrician. ______

I am not pregnant, intending on becoming pregnant, or breast feeding. ______

Patient's Signature ______________________________ Date________________

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

HIPAA requires a pharmacy practice to make a good faith effort to obtain a signed Acknowledgement from the patient at the time that it provides the HIPAA Notice of Privacy Practices to the patient.

I acknowledge that I have received a copy of Bluepoint Apothecary's **HIPAA Notice of Privacy Practices**.

____
Patient Name (Please Print)

______________________________ ______________________
Patient Signature Date

OR

____
Signature of Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

□ Parent □ Guardian □ Power of Attorney □ Other:____________

Please Note: It is your right to refuse to sign this Acknowledgement.

Office Use Only

I tried to obtain written Acknowledgement by the individual noted above of receipt of our **Notice of Privacy Practices**, but it could not be obtained because:

□ An emergency prevented us from obtaining acknowledgement.

□ A communication barrier prevented us from obtaining acknowledgement.

□ The individual was unwilling to sign.

□Other:______________________

____
Staff Member Signature Date