ANNAPOLIS FAMILY MEDICINE

104 Ridgely Avenue, Suite 302
Annapolis, Maryland 21401
Phone: (410) 280-9500
Fax: (443) 214-5168
AFM@annapolisfamilymedicine.org
www.AnnapolisFamilyMedicine.org

Medicinal Cannabis Management Contract

Patient Name: _____ DOB: _____

I request that an Annapolis Family Medicine doctor or nurse practitioner certify me as a qualifying patient under the Maryland Medical Marijuana Act so that I can legally use marijuana to treat my medical condition. I verify that I have a medical condition which causes severe and often debilitating discomfort. I have tried and failed multiple standard medical therapies which have not corrected the problem.

CHOOSE ONE BELOW

☐ I am currently taking controlled prescription medications to relieve discomfort. I am not getting adequate relief and am very concerned about the long term use of controlled prescription drugs for pain. I am seeking an alternative therapy so that I can stop the use of these potentially harmful drugs.

☐ I am currently not taking any medications for my pain, due to associated problems with those medications. I need relief of chronic pain or disability and am seeking alternative therapies.

My diagnosis for which I am seeking an alternative therapy is _____.

	Initial
I verify that this is documented and that statements I am making are correct and accurate.	
I understand that the use of cannabis is a non FDA approved medical treatment. Because this drug therapy has not been fully tested by the FDA, I understand that my physician or NP at AFM does not fully understand the benefits and the potential risks of cannabis use.	
I accept full responsibility for any and all risks associated with the use of cannabis. This includes but is not limited to the following: altered mental status, confusion, respiratory problems and multiple possible side effects. Caution should always be used if one has a respiratory problem and is using an inhaled substance. Caution should be used in all areas of life, including but not limited to child care, operating any equipment, driving an automobile, use of any dangerous equipment, explosives, or firearms, and in any job which requires attention to detail and mental clarity.	
I understand that the State of Maryland has approved cannabis for the treatment of certain medical conditions, but this has not been approved by the U.S. Government. Thus future use is uncertain.	

I agree to the following:

1. I will not use illegal drugs.
2. I understand that by using medicinal cannabis, I may be voiding my contract with pain management, and I will notify my pain management doctor of my use of cannabis. I understand that using cannabis concurrently with opioids, benzodiazepines and other psychoactive substances is not encouraged. I agree to attempt to wean my dosages or frequencies of these medications down while using medical cannabis. If I am a patient of AFM who receives benzodiazepines or opioids from this office, I must agree to weaning of my prescriptions in order to add medical cannabis. The goal is to be on either/or, not both.
3. I agree to providing a verifiable drug screen test when requested. All females of reproductive age will also need a pregnancy test with the initial visit and before each follow up.
4. I agree to a follow up visit every 12 months for renewal of this certification.
5. I agree to follow up closely with my treating physician.
6. I agree that any violation in the terms of this contract will result in the termination of the certification.
7. I agree to authorize AFM to cooperate fully with city, state, or federal law enforcement agencies in their review of this contract and treatment plan, and in the investigation of any possible misuse of my medical marijuana.
8. I authorize AFM to provide a copy of this agreement to any of my specialists, local emergency departments, and other health providers as needed.

_____ _____

Patient/Representative Signature Date

_____

Provider Signature