

# Medication Management Agreement

The decision to use medical Marijuana Therapy was made because of my specific condition or because other treatments have not relieved my condition and/or pain. As I am requesting certification for the use of medical marijuana, when I sign this form I acknowledge that I understand and agree to the following conditions to make my treatment as safe and successful as possible

**(please initial each numbered item):**

- \_\_\_\_\_ 1. I am aware that the use of such medicine has certain risks associated with it, including but not limited to: sleepiness or drowsiness, hallucinations, paranoia, anxiety, memory loss, lung disease, dizziness, allergic reaction, slowing of reflexes or reaction time, habituation, increase heart rate, decrease blood pressure on standing, tolerance to analgesia (pain reduction), habituation, and the realization that the medicines will not provide complete relief.
- \_\_\_\_\_ 2. I understand that the main treatment goal is to improve my ability to function by Reducing pain or symptoms related to my condition. In consideration of that goal, I agree to help myself by following better health habits: exercising, controlling my weight, and avoiding the use of alcohol and tobacco. I understand that only by following a healthier lifestyle can I hope to have the most successful outcome to my medical marijuana therapy.
- \_\_\_\_\_ 3. I understand that the long-term advantages and disadvantages of chronic use of marijuana have yet to be fully determined and researched. I understand, accept, and agree that unknown risks may be associated with the use of marijuana. I also know there are other available medical and alternative therapies.
- \_\_\_\_\_ 4. I agree to tell my doctor about all other medicines and treatments that I am receiving. to fail to tell my doctor about all other medicines and treatments that I am receiving may endanger my health and/or physician/patient relationship.
- \_\_\_\_\_ 5. I agree to **keep all appointments with my primary doctor(s) and specialists for my condition.**
- \_\_\_\_\_ 6. I understand that driving a motor vehicle may be hazardous while receiving medical Marijuana therapy and that it is my responsibility to comply with the laws of this State and conduct myself safely while taking the medication prescribed.
- \_\_\_\_\_ 7. I will not be involved in activities that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction time might still be slowed. Such activities include but are not limited to: using heavy equipment or operating a motor vehicle, working at unprotected heights, or being responsible for another individual who is unable to care for himself or herself.
- \_\_\_\_\_ 8. I have been fully informed by the doctor regarding the potential psychological dependence on a controlled substance. I know that some persons may develop a tolerance, which is the need to increase dose of the medication to achieve the desired effect.
- \_\_\_\_\_ 9. I am aware of the controversies and have read the regulation regarding the use of medical marijuana in Hawaii and that it remains an illegal Class I Controlled Substance under Federal Law. As of this date there is no medical marijuana Reciprocity with other states.

**I have read this agreement. I fully understand the consequences of violating this agreement. The doctor has answered my questions and I agree to the terms of the agreement.**

**Patient name:** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_