INFORMED CONSENT

I am being evaluated for a physician's certification that I meet the criteria set forth in Oklahoma State law for medical cannabis. The physician will make this certification based, in part, on the medical information I have provided. I have not misrepresented my medical condition in order to obtain this recommendation, and it is my intent to use cannabis only as needed for the treatment of my medical condition, not for recreational or non-medical purposes. I understand that it is my responsibility to be informed regarding state and federal laws regarding the possession, use, growing, sale/purchase, and/or distribution of cannabis.

I have been informed of and understand the following: **Please initial**

_____• I must be an Oklahoma resident to obtain an approval or recommendation for the use of cannabis.

_____• The federal government has classified cannabis as a Schedule III controlled substance. Federal law prohibits the manufacture, distribution, and possession of cannabis even in medically legal states, which have modified their state laws to treat cannabis as a medicine.

_____• Cannabis has not been approved by the Food and Drug Administration for marketing as a drug. Therefore, the "manufacture" of cannabis for medical use is not subject to any standards, quality control, or other oversight. Cannabis may contain unknown quantities of active ingredients, impurities, contaminants, and substances in addition to Delta-9 THC, the primary psychoactive component.

_____• The use of cannabis can affect coordination, motor skills, and cognition. While using cannabis, I should not drive, operate heavy machinery, or engage in activities requiring alertness or quick responses. Driving under the influence of cannabis is illegal.

_____• Potential side effects of cannabis include dizziness, anxiety, confusion, sedation, low blood pressure, impaired short-term memory, euphoria, difficulty completing complex tasks, immune suppression, inability to concentrate, impaired motor skills, paranoia, psychotic symptoms, apathy, depression, and restlessness. Cannabis may worsen schizophrenia in predisposed individuals.

_____• Using cannabis while under the influence of alcohol is prohibited by law. Additional side effects may occur when combining alcohol and cannabis.

_____• I agree to contact my physician if I experience any of the above side effects, or if I become depressed, psychotic, suicidal, or experience significant emotional changes. If I cannot reach my physician, I will go to the nearest emergency room.

_____• Smoking cannabis may cause respiratory problems, including bronchitis, emphysema, and laryngitis. Cannabis smoke contains carcinogens and tars that may increase the risk of respiratory diseases and cancers. If respiratory symptoms occur, I will stop using cannabis and notify a physician.

_____• The risks, benefits, and drug interactions of cannabis are not fully understood. If I am taking medication or undergoing treatment, I understand that I should consult with my treating physician(s) before using cannabis and should not discontinue any prescribed treatment unless advised by my physician(s).

_____• Individuals may develop tolerance or dependence on cannabis. If I require higher doses or believe I may be developing dependency, I will contact my physician or seek treatment with a primary care or addiction specialist.

_____• Psychological withdrawal symptoms may include depression, irritability, insomnia, restlessness, agitation, loss of appetite, difficulty concentrating, and unusual fatigue.

_____• Symptoms of cannabis overdose include nausea, vomiting, coughing, heart rhythm disturbances, numbness, anxiety attacks, and incapacitation. If these occur, I will go to the nearest emergency room.

_____• If my physician learns that I have provided false or misleading information, my recommendation may be revoked, and the Cannabis Control Commission may be notified. I agree to provide additional information if inaccuracies are discovered.

_____• I have had, or will have, the opportunity to discuss these matters with the clinician and ask questions about anything unclear. The clinician has informed me of the risks and complications of any recommended treatment.

Patient Signature: _____

Date: _____