Dr. Gregory Scher

MBBS, FRACGP, DCH.

Medicinal Cannabis Consent Form

# PATIENT’S DETAILS

Title Surname Given Name(s)

Date of Birth / /

# MEDICINAL CANNABIS QUESTIONAIRE

What is the primary diagnosis or medical condition you are looking to treat with medicinal cannabis?

Chronic Pain Anxiety Insomnia

Other conditions

Have you previously or are you currently self-medicating with cannabis?

Yes No

What other treatments have you trialled for this condition?

What other medications have you previously used, list the side effects if any, and reason for stopping?

Do you currently experience, or have a history of the following?

Psychosis Bipolar Disorder

Mood disorder or severe anxiety Cardio-respiratory disease Pregnant or breastfeeding

Drug dependence or substance abuse

# PATIENT DECLARATION & CONSENT

I understand that the long-term side effects of medicinal cannabis are unknown.

Yes No

I understand that medicinal cannabis is an unregistered medicine in Australia.

Yes No

I understand that the quality, safety and efficacy of medicinal cannabis has not been assessed by the Australian government’s Therapeutic Goods Administration (TGA).

Yes No

I understand that the prescribing doctors will report my treatment outcomes to the state government.

Yes No

I understand that the cost of medicinal cannabis is solely my responsibility.

Yes No

I understand that I am not able to drive whilst taking medicinal cannabis and if I drive I am breaking the law. A legally issued prescription is not protecting against these laws.

Yes No

I understand the risks and complications associated with medicinal cannabis treatment and I agree to follow my doctor’s recommendation with regards to dosing and report any adverse effects of medicinal cannabis, including changes in the levels of sedation, lethargy, fatigue, dry mouth, nausea, vomiting, diarrhoea, drowsiness, dizziness, disorientation, agitation, balance problems, changes in memory, paranoid delusions, or hallucinations.

Yes No

I understand that there is a possibility of unknown risks and late side effects.

Yes No

I understand that medicinal cannabis might interact with my other medications and doses may need to be adjusted according.

Yes No

I agree to keeping a log of my doses and changes in symptoms due to medicinal cannabis.

Yes No

I agree to regular follow up consultations in the surgery or over the phone and indicated by my doctor.

Yes No

I agree that I will not use any other forms of cannabis other than what is prescribed by my doctor, this includes any illicit forms of cannabis (marijuana).

Yes No

I agree to notify my prescribing doctor of any changes in my other medications.

Yes No

I agree to share my clinical outcomes for research purposes.

Yes No

I, , declare that all answers in this Medicinal Cannabis Patient Intake & Consent Form are true and correct to the best of my knowledge and belief.

Signature of patient or guardian: Date: