Your Clinic Name

Medical Cannabis Treatment Agreement

1. I _____ agree that Dr. _____ (my prescriber) will be the only prescriber providing me with medicinal cannabis and I will obtain all of my medicinal cannabis with the same Health Canada authorized licensed producer. The exception would be in an emergency situation or in the unlikely event that I run out of medical cannabis due to a prescribing or dispensing error. In such cases, I will inform my prescriber as soon as possible. I am aware that possession of medical cannabis from other sources other than a Licensed Producer (LP) is illegal.

2. I agree to attend all reasonable appointments, treatments, and consultations as requested by my doctor/prescriber

3. I will take medical cannabis at the recommended dose and frequency indicated by my doctor/prescriber.

4. I understand that the common side effects from medical cannabis may include, drowsiness, dizziness, mental slowness, changes in perception of my senses and nausea. Drowsiness and changes in perception may occur when starting medical cannabis, when increasing the dosage, method of consumption, changing the species/strain or preparation. I agree to refrain from driving a motor vehicle or operating dangerous machinery until such drowsiness or perceptual changes disappears.

5. Addiction is a potential risk when taking medical cannabis. I understand, that urine drug testing may be required as part of my medical cannabis treatment regime.

6. I am aware that taking medical cannabis with other substances, especially sedating substances, may cause harm. If I use illegal drugs (e.g. cocaine, heroin, ecstasy), or controlled substances (e.g. narcotics, stimulants, anxiety pills) that were not prescribed for me, my prescriber may refuse to continue prescribing medical cannabis.

7. I also agree that my doctor/prescriber has my consent to contact any other health care provider, your LP, legal authority, or regulatory agency to obtain or provide information including my personal health information related to any potential misuse/ abuse of medical cannabis.

8. I agree to be responsible for the secure storage of my medical cannabis at all times. I agree not to give, share or sell my medical cannabis to any other person. **I am aware that selling of cannabis is an illegal activity**.

9. I understand that my doctor/prescriber will not replace lost medical cannabis.

10. I understand that using recreational cannabis may result in your doctor/prescriber refusing to continue prescribing
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11. I understand that cannabis is associated with psychosis in persons who are still undergoing neurodevelopment (brain growth). Therefore, I will ensure that no person under the age of 25 years has access to my cannabis.

12. I am aware that cannabis is not advisable during pregnancy and breastfeeding. I agree to inform my prescriber if I am pregnant, breastfeeding or intending to become pregnant.

13. I understand that if I break this agreement, my doctor/prescriber reserves the right to stop prescribing medical cannabis for me.

Signed at the _____ Clinic on _____
(date) (yyyy/mm/dd)

_____ _____
(Patient Printed Name) **(Health Care Professional Printed Name)**

_____ _____
(Patient Signature) **(Signature & Designation)**