Patient Name: _____ Date: _____

Medicinal Cannabis Treatment Agreement

Medicinal cannabis is recommended for use to relieve pain. Along with medicinal cannabis, other medical care may be prescribed to improve your ability to do daily activities. This may include exercise, use of prescription medications, physical therapy, psychological counseling or other types of therapy. **This is not a prescription for medicinal cannabis.**

I, _____, understand that following the below guidelines is important to my care. If I have problems following these guidelines, I will discuss this with my provider so that my treatment plan can be adjusted appropriately.

I understand that I have the following responsibilities:

- I am responsible for obtaining my own cannabis and following all WA State laws regarding the use of medicinal cannabis.
- I will look for medication with at least _____% CBD and less than _____% THC.
- I will start with a low dose, and increase my dose gradually, after contacting you, if my pain is not relieved.
- I am committed to continue to receive medical care with you or another provider, so that medicinal cannabis effectiveness can be assessed and side effects can be monitored.
- I will inform you of all medications I am taking.
- I will not use alcohol or other sedating medications at the same time as cannabis without first discussing this with you.
- I will not drive or operate heavy machinery for several hours after using cannabis, or any time I am feeling the effects of cannabis.
- I will store my cannabis securely in a child-proof container, and protect it from being accessed by minors.
- I will not share my cannabis with anyone.
- I agree to be monitored for psychological and dependency problems, and to obtain treatment if recommended. This treatment could include attending counseling sessions, group meetings, or another form of therapy.

I understand that you may stop recommending cannabis if:

- I do not show improvement in mobility and my pain is not relieved,
- My behavior is inconsistent with the responsibilities listed above,
- My use of cannabis becomes problematic or interferes with my ability to do daily activities,
- I am misusing other drugs,
- I am unable to keep my appointments.

In addition, it is recommended that I keep a diary of all the medications I am taking, including dose and time taken each day.

Method of consumption:

❑ inhalation _____

❑ ingestion _____

❑ topical _____

Patient Signature_____ Provider Signature _____

Date: _____/_____/_____ Date: _____/_____/_____

Note to Provider: Keep signed originals in your file. Give a copy to the patient. This should be renewed every six months.