

MEDICAL CANNABIS OF SOUTHERN CALIFORNIA
Annual Renewal Form

Name _____ Date _____

Age _____

Since your last visit have you changed your address?

If yes to any please update our records:

Cell phone: _____ Email: _____

Do we have permission to send you a reminder to renew your medical recommendation in 12 months?

Yes ___ No ___

Are you currently on probation? ___ or parole? ___

In the past 12 months:

1) Has your medical history changed (i.e. received a new diagnosis, changed medications, MRI's CT Scans, 2) X-Rays)? Yes ___ No ___

If yes please specify:

2) Have you visited your primary care physician? Yes ___ No ___

If yes specify date, physician's name/address and reason for visit: _____

3) Have you been hospitalized for any reason (surgery or illness)? Yes ___ No: ___

If yes specify date, hospital and reason for hospitalization: _____

4) Have you been evaluated by a specialist (i.e. Neurologist, Pain Specialist)? Yes ___ No ___

If yes specify date, physician and reason for visit: _____

5) Have you started taking any new medications? Yes ___ No ___

If yes please specify: _____

6) Have your drinking, drug use, or cigarette smoking habits changed? Yes ___ No ___
If yes please specify: _____

7) Are you renewing your cannabis recommendation for the same diagnosis/symptom as last year? Yes ___
No ___

If yes what is your diagnosis: _____

If no, please specify the exact reason you are seeking a cannabis recommendation:

8) On average, how often did you medicate with cannabis? _____
Did you primarily Vaporize? ___ Edibles? ___ Topical? ___ Smoke ___

9) Did cannabis help relieve your symptoms? Yes ___ No ___
If yes, please describe how cannabis helped you (i.e. "Less Pain" "Improved Sleep" "Relieved anxiety")

10. Females ONLY: Are you currently taking birth control? Yes ___ No ___
Are you currently pregnant? Yes ___ No ___
Are you currently breast feeding? Yes ___ No ___

Patient Signature _____ Date _____

Physicians Comments (leave blank)

Physicians Signature _____ Date ___/___/___

Dr. Sean Breen, PC
DBA: Medical Cannabis of Southern California (MCSocal)
Informed Consent, Release of Liability and Patient Acknowledgement

Please Initial Next to Each One:

_____ I understand that I must be a California Resident to obtain an approval or recommendation for the use of cannabis (medical marijuana) under California's Compassionate Use Act of 1996 (Health and Safety Code #11362.5).

_____ I affirm that I have a serious medical condition that adversely affects my quality of life. I have found or am interested in finding whether cannabis provides substantial relief and improvement in my condition.

_____ I understand that the cannabis plant is not regulated by the United States Food and Drug Administration and therefore may contain unknown quantities of active ingredients, impurities and/or contaminants. In requesting an approval or recommendation for the use of this plant as medication I assume full responsibility for any and all risks of this action.

_____ I am advised that the cannabis smoke contains chemicals known as tars that may be harmful to my health. Recent research indicated that vaporizing cannabis might eliminate exposure to tar. Should respiratory problems or other ill effects be experienced in association with its use, it should be discontinued and reported to a physician.

_____ I am advised that the use of cannabis may affect my coordination and cognition in ways that could impair my ability to drive, operate heavy machinery, or engage in potentially hazardous activities. I assume full responsibility for any harm resulting to me and/or other individuals as a result of my use of cannabis.

_____ California's Compassionate Use Act of 1996 (health and Safety Code #11362.5) provides for the possession and cultivation of cannabis for the personal medical purposes of a patient with physician approval or recommendation. It should be made absolutely clear that the physician, staff, management and representatives of this practice are neither providing cannabis, nor are they encouraging any illegal activity to my obtaining cannabis.

_____ I, the undersigned, hereby request a consultation by a physician for purposes of determining the appropriateness of medical cannabis treatment. There are no claims about the medical efficacy of cannabis. The physician, staff, management and representatives of this practice are addressing specific aspects of my medical care and, unless otherwise stated, are in no way establishing themselves as my primary care provider. Should an approval be made for my medical use of cannabis, I understand that there is an expiration of this approval at a date specified by the physician.

_____ I understand that it is my responsibility to see a physician to assess the possible continuance of cannabis use beyond the approval expiration date. Furthermore, I, the undersigned, my heirs, or anyone acting on my behalf, hold the physician and his/her principals, agents, employees and management harmless and free from any liability resulting from the use of cannabis.

_____ If anything changes with my medical condition, I will notify Medical Cannabis of Southern California immediately.

_____ I understand that Medical Cannabis of Southern California may be contacted to verify the information contained in my physician's letter of recommendation. I hereby authorize the staff of Medical Cannabis of Southern California to discuss my medical condition and the contents of my physician's letter of recommendation for verification purposes.

_____ I understand the cultivation, distribution, possession, and use of marijuana is federally illegal. The federal government has classified marijuana as a Schedule I controlled substance. Scheduled I substances are defined, in part, as having (1) a high potential for abuse; (2) no currently accepted medical use in treatment in the U.S.; (3) a lack of accepted safety for use under medical supervision. Federal law prohibits the manufacture, distribution and possession of marijuana even in the states, such as California, which have modified their state laws to treat marijuana as medicine.

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_____ I understand that potential side effects from the use of marijuana include, but are not limited to, the following: dizziness, anxiety, confusion, sedation, low or high blood pressure, impairment of short-term memory, memory, euphoria, difficulty in completing complex tasks, suppression of the body's immune system, inability to concentrate, impaired motor skills, paranoia, psychotic symptoms, general apathy, depression and/or restlessness. Marijuana may exacerbate schizophrenia in persons predisposed to that disorder. In addition, the use of marijuana may cause me to talk or eat in excess, alter my perception of time and space and impair my judgment.

_____ I agree to contact MCSOCAL if I experience any of the side effects listed above, or if I become depressed or psychotic, have suicidal thoughts, or experience crying spells. I will also contact MCSOCAL if I experience respiratory problems, changes in my normal sleeping patterns, extreme fatigue, increased irritability, or begin too withdraw from my family and/or friends.

_____ I understand that the risks, benefits and drug interactions of marijuana are not fully understood. If I am taking medication or undergoing treatment for any medical condition, I understand that I should consult with my treating physician(s) before using marijuana and that I should not discontinue any medication or treatment previously prescribed unless advised to do so by the treatment physician(s).

_____ I understand that individuals may develop a tolerance to, and/or dependence on, marijuana. I understand that if I require increasingly higher doses to achieve the same benefit or if I think that I may be developing a dependency on marijuana, I will contact the physician at MCSOCAL

_____ I understand that signs of withdrawal can include: Feelings of depression, sadness, irritability, insomnia, restlessness, agitation, loss of appetite, trouble concentrating, sleep disturbances and unusual tiredness

_____ I understand that symptoms of marijuana overdose include, but are not limited to, nausea, vomiting, hacking cough, disturbances in heart rhythms, numbness in the hands, feet, arms or legs, anxiety attacks and incapacitation. If I experience these symptoms, I agree to contact the physician at MCSOCAL immediately or go to the nearest emergency room.

_____ If the physician or staff at MCSOCAL subsequently learn that the information I have furnished is false or misleading, the recommendation for marijuana may no longer be valid. I agree to promptly meet with the physician at MCSOCAL and/or provide additional information in the event of any inaccuracies or misstatements in the information I have provided

_____ I have had the opportunity to discuss these matters with the physician and to ask questions regarding anything I may not understand or that I believe needed to be clarified

_____ I acknowledge and represent that I am a resident of California. I acknowledge and represent that I am over 21 years of age, or that I am over 18 years of age with an accompanying parent. I acknowledge and represent that I am not an agent of law enforcement, state or federal government, here for the purpose of investigation or entrapment. I acknowledge and represent that I am not recording any portion of my visit with MCSOCAL nor do I possess any recording equipment. I understand MCSOCAL does not approve such action

Signed: _____ Date: _____

Print Name: _____