

Please indicate the condition for which you are recommending marijuana (circle letter). You may circle more than one condition:

- a. Cancer, glaucoma or positive status for human immunodeficiency virus, or acquired immune deficiency syndrome when the condition or disease results in symptoms that seriously and adversely affect the patient’s health status;
- b. Cachexia or wasting syndrome
- c. Intractable nausea or vomiting
- d. Epilepsy or an intractable seizure disorder
- e. Multiple sclerosis
- f. Chron’s disease
- g. Painful peripheral neuropathy
- h. A central nervous system disorder resulting in chronic, painful spasticity or muscle spasms
- i. Admittance into hospice care
- j. Severe chronic pain

PART B:

In a statement, or in attached documentation:

- 1. Specify the patient's debilitating medical condition. Describe the condition, why it is debilitating and to what extent it is debilitating.
- 2. Describe medications, procedures and other medical options used to treat the condition and state that these options have not been effective.
- 3. List restrictions to the patient’s activities due to the use of marijuana.

Specify the time period for which the use of marijuana would be appropriate (not to exceed one year).

In signing this form, I certify:

- a. I am a physician duly licensed to practice medicine in Montana under MCA Title 37, Chapter 3.
- b. I have assumed primary responsibility for providing management and routine care of this patient.
- c. Having completed a full assessment of the patient’s medical history and current condition, in the course of the medical care and supervision I have provided, this patient has a debilitating medical condition as described above.
- d. I have reviewed all prescription and non-prescription medications and supplements used by this patient, and have considered the potential drug interaction with marijuana.
- e. I have a reasonable degree of certainty that this patient’s condition would benefit from the use of medical marijuana and the potential benefits of medical marijuana will likely outweigh the health risks for this patient.
- f. I have described the potential risks and benefits of the use of marijuana to this patient.
- g. I will continue to serve as this patient’s treating physician and will supervise the use of medical marijuana and evaluate the efficacy of the treatment.
- h. I am this patient’s treating physician

Physician’s Signature

Date

PART C:

A SECOND PHYSICIAN MUST COMPLETE THE FOLLOWING, AFTER PERFORMING A PHYSICAL EXAMINATION OF THE MINOR PATIENT:

Initial each statement:

1. I have conducted a comprehensive review of the minor's medical records as maintained by the treating or referral physician _____
2. It is my professional opinion that the potential benefits of the use of marijuana would likely outweigh the health risks for the minor _____
3. The information provided in this written certification and accompanying statements is true and correct _____

I, being a second physician who has examined the above named patient, independent of the treating physician, concur with his/her diagnosis of the patient's chronic pain.

Second Physician's Signature

Date

Second Physician's Name: _____

Montana License Number: _____

Street Address, City, State, Zip (second physician's office): _____

Second Physician's mailing address, City, State, Zip:

Second Physician's Telephone Number: _____ Business Email: _____

Is any of the information above new information that needs to be updated in the Montana Marijuana System?

Yes

No

Please give the **original** form to the patient