MONTANA
Department of Public Health & Human Services

Montana Marijuana Program
PHYSICIAN'S STATEMENT for MINORS

Minor registered cardholder applicants with a chronic pain diagnosis must use this form when applying for the Montana Marijuana Program Registry. A *medical doctor* or *doctor of osteopathy* must complete this form for the minor registered cardholder applicant. **Completion of this form does not constitute a prescription for marijuana.**

PHYSICIAN AND PATIENT: READ THE CHECKLIST BEFORE SENDING THIS FORM TO THE DEPARTMENT

- ✓ Questions one, two and three in PART B *must* be addressed in the space provided, or in attached documentation.
- ✓ A *second* physician's signature is required in PART C.
- ✓ A Minor Patient Application is also required with this form. A Minor Patient Application can be found at http://dphhs.mt.gov/marijuana under "Forms".

Patient Name: _____ Patient DOB: _____
Last First MI

PART A:
This information must match the information on file with the Montana Board of Medical Examiners:

Physician's Name: _____ Montana License Number: _____

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

_____

Mailing address, City, State, Zip: _____

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

Initial one *or* two below:

1. I am the patient's treating physician and this patient has been under my ongoing medical care as part of a bona fide professional relationship _____

   OR;

2. I am the patient's referral physician _____

MONTANA
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Please indicate the condition for which you are recommending marijuana You may check more than one condition:

- ☐ 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
- ☐ Cachexia or wasting syndrome
- ☐ Intractable nausea or vomiting
- ☐ Epilepsy or an intractable seizure disorder
- ☐ Multiple sclerosis
- ☐ Crohn's disease
- ☐ Painful peripheral neuropathy
- ☐ A central nervous system disorder resulting in chronic, painful spasticity or muscle spasms
- ☐ Admittance into hospice care
- ☐ Severe chronic pain that is persistent pain of severe intensity that significantly interferes with daily activities as documented by the patient's treating physician
- ☐ Post-traumatic stress disorder (PTSD)

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.

MONTANA
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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

MONTANA
Department of Public Health & Human Services

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.

_____ _____

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

Print Form Clear Form