



Montana Marijuana Program
PHYSICIAN STATEMENT for a DEBILITATING MEDICAL CONDITION for Minors

Minor registered cardholder applicants with a debilitating medical condition 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.

PHYSICIANS 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.
- ✓ Forms must be filled out completely and may not be modified or edited in any way.
- ✓ A minor patient application is also required with this form. Patients should create an account with Complia and apply at <https://mt-public.mycomplia.com/> Patients who lack access can contact the Medical Marijuana Program for alternate accommodations.

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: _____

Physician Office Physical Address, City, State, Zip: _____

Physical Address of Patient Assessment: _____

Physician Mailing Address, City, State, Zip: _____

Physician's Telephone Number: _____

Is any of the information above new information that needs to be updated in the 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 AND I have assumed primary responsibility for providing management and routine care of the patient's debilitating medical condition after obtaining a comprehensive medical history and conducting a physical examination that included a personal review of any medical records maintained by other physicians and that may have included the patient's reaction and response to conventional medical therapies (§ 50-46-310 (2)(d) MCA).

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
- Severe chronic pain that is persistent pain of severe intensity that significantly interferes with daily activities as documented by the patient's treating physician
- 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
- 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.



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

This patient assessment was conducted via telemedicine in accordance with §§ 50-46-302 (26), (28), 50-46-310 (2)(d), (4) MCA (Effective May 3, 2019 with passage of SB265) Yes No

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 am this patient's treating physician or referral physician and I have assumed primary responsibility for providing management and routine care of this patient's debilitating medical condition that qualifies patient for this recommendation.
- 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 marijuana and the potential benefits of 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 marijuana and evaluate the efficacy of the treatment.
- h. The information provided in this written certification is true and correct.

Physician's Signature: _____ Date of assessment: _____



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_____

Second Physician’s Name: _____ Montana License Number: _____

Second Physician Office Physical Address, City, State, Zip:

Physical Address of Patient Assessment with Second Physician:

Second Physician Mailing Address, City, State, Zip:

Second Physician’s Telephone Number: _____

Is any of the information above new information that needs to be updated in the Marijuana System? Yes No

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 of assessment: _____

Please give the completed original form to the patient