Montana Medical Marijuana Program

PHYSICIAN STATEMENT for a DEBILITATING MEDICAL CONDITION

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 registered cardholder applicant.

Completion of this form does not constitute a prescription for marijuana.

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

- ✓ The physician completing this form must respond to items one, two and three on page two in the space provided or in attached documentation.
- ✓ Forms must be filled out completely and may not be modified or edited in any way.
- ✓ A 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

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)

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 per MCA 50-46-310 (2)(k)): _____

Should there be a need to identify this time period for longer than one year, please indicate this in a response to question #1 on page 2 of this form. Per MCA-46-303 (7)(a), even if the physician recommends more than one year, the registry identification card will expire 1 year after the date of issuance unless a physician has provided a written certification stating that a card is valid for a shorter period of time.

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: _____

Please give the completed original form to the patient