CANN MED. PC.

Danny W Hernández MD, CIME

610.419.3388 info@cannmedpc.com

1707-1709 W. Hamilton St Allentown, PA 18104

4518 City Ave. 3rd fl. Philadelphia, PA 19004

2981 Grant Avenue Philadelphia, PA 19114

274 Susquehanna Avenue Wyoming, PA 18644

(P) 610-419-3388 (F) 610-419-3266

Receipt of Payment

Patient Name: _____

Date of Service: _____

Amount Paid: $_____

Reason: ___ Initial Consult

___ Re-Certification

Follow up instructions:

1. After Dr. Hernandez enters certification into Pa.gov website, you will receive an email notifying you of entry.
2. Please log back to pa.gov and use your user name and password.
3. If you do not get an email, go directly to website, and use your user name and password you created when you registered.
4. Pay the $50 fee to the State for the ID card, please make sure you use a desk top computer, the website is not configured for tablets or cell phones. Chrome is preferred.
5. The card will be sent directly to the address you had registered.
6. Make an appointment with the Pharmacist the dispensary of your choice to discuss the different modes and strains of medical marijuana that best suits your needs.
7. Make an appointment prior to the expiration of your certification by calling 610-419-3388 or 610-419-1587.
8. You will have to renew your online registration with Pa.gov prior to your next visit.
9. The cost for re-certification will be $150.

Thank you for choosing CANN Med PC.

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Medical Marijuana Patient Information Sheet

Patient ID (from portal): _____

First Name: _____ Last Name: _____

Date of Birth: _____

Email Address: _____

Address: _____

Phone Number: _____

Contract for Marijuana Recommendation in the State of Pennsylvania

1. This is an agreement between (name): _____and Dr. Danny Hernandez (CANN MED, PC) concerning the use of Marijuana for the treatment of (Reason) _____.

I, (name) _____, request treatment of my condition with marijuana. As a result, I expect that I may become more functional and improve my quality of life. I have been treated with other therapies for my condition, which have not provided adequate relief of my symptoms.

2. I understand that marijuana is a strong drug and that there is insufficient scientific evidence to confirm its use for clinical purposes. There is also insufficient evidence on the clinical risks and benefits of this drug, including the proper dosage to be used for various medical conditions and symptoms, and the potential interactions between this drug and other medications. As such, I understand my physician may not be knowledgeable about all the risks associated with marijuana use.

Risks and Side Effects

3. I have been informed of the known risks and side effects of taking marijuana including, but not limited to: facial flushing, red eyes, dry mouth, drowsiness, sedation, dizziness, fainting, clumsiness, confusion,

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fuzzy thinking, impaired attention, impaired concentration, impaired short term memory, agitation, anxiety, paranoia, delusions, hallucinations, amnesia, fast or slow heartbeat.

4. When I first start taking marijuana, I may experience the adverse mood reactions noted above. With long term use of marijuana, the effects on attention, concentration and short term memory may worsen and can persist after I stop using marijuana.

5. If I smoke marijuana, I may develop a cough and/or wheeze which may persist with long term use and may result in lung damage.

6. I understand that some side effects of marijuana are made worse when used with other medication; for example drowsiness, sedation and dizziness are worse when marijuana are used with sleeping medication, tranquilizers, pain medications, antihistamines and seizure medications to name a few. I understand it is my responsibility to inform my physician of any and all side effects I have with this medication.

7. I understand that if I am pregnant or become pregnant while taking marijuana, my child may acquire behavioral and attention problems as a result of prenatal exposure to marijuana, as well as other unknown complications. It is believed there is also an increased risk of sudden infant death syndrome in babies born to mothers using marijuana in pregnancy.

Authorization (Prescription)

8. I agree to take marijuana as prescribed by my physician and not to change the amount or frequency of my marijuana use without first discussing it with my prescribing physician. Running out early, needing early refills, escalating doses without permission and losing any marijuana may be signs of misuse and may be reasons for my physician to discontinue prescribing marijuana to me.

9. I agree not to ask my physician for extra marijuana if I use up my supply early or if I lose or misplace my marijuana. I understand I will have to wait until the next allotment is due.

10. I agree that my marijuana will only be prescribed by Dr. Danny Hernandez (CANN MED, PC), unless in an absolute emergency, and if this be the case, I will inform Dr. Danny Hernandez (CANN MED, PC), as soon as possible.

11. I understand I may access my marijuana in the State of Pennsylvania by visiting https://www.pa.gov/guides/pennsylvania-medical-marijuana-program and following guidelines and protocols. The website also includes list of providers, and dispensaries.

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12. I agree not to accept marijuana from anyone, other than my Licensed Producer or my designated producer.

13. I agree to notify my physician if I change the means by which I obtain my marijuana.

14. I agree not to take any pain medications or mind altering medications other than those prescribed to me by my physician Dr. Danny Hernandez (CANN MED, PC). I will not seek such prescriptions from other physicians.

15. I agree to tell any other physician who might treat me that I take marijuana for medical reasons.

16. I agree to tell my physician if I get any new medications prescribed to me by any other physician and if any doses of my current medications are changed by another physician.

17. I agree not to drink alcohol or take other mood altering drugs (tranquilizers, sleeping pills, other mood stabilizers) unless they are prescribed to me by my physician. I understand that using marijuana with other drugs may lead to an overdose.

18. I agree to tell my physician all medications I am taking including over the counter drugs, herbs, vitamins, etc.

Legal Implications

19. If marijuana causes me to become drowsy, sedated or dizzy, I understand I must not drive a motor vehicle (including all terrain vehicles, snowmobiles, boats) or operate machinery that could put my life or someone else's life in jeopardy. My physician has a legal obligation of the PA Highway traffic Act to inform the Registrar of Motor Vehicle of my clinical condition and that my treatment may make it dangerous for me to drive. If I do drive while using marijuana, I can be charged with Impaired Driving. If I am charged with impaired driving, while using marijuana, I agree that Dr. Danny Hernandez (CANN MED, PC) is not to blame and will not be named in any resulting legal action. I accept full responsibility for any and all risks associated with the use of marijuana.

20. I agree to keep my marijuana in a safe and secure place, away from children. Lost, stolen or damaged marijuana will not be replaced. I will report any stolen marijuana to the police and my physician immediately.

21. I agree not to share, sell, lend trade, transport/ship marijuana or in any way give my marijuana to any other person. I realize this is an illegal act. I also agree that my physician and my pharmacist may work with the police to look into any alleged misuse or sale of my marijuana.

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22. I give permission to the above named physician to verify that I am not seeing other physicians for prescriptions of marijuana, opioids or other mind altering medications and to verify that I am only going to one licensed producer/distributor or one designated producer. It is illegal to obtain prescriptions for controlled substances and/or marijuana from two different physicians at the same time ("double doctoring").

23. I agree not to use any illegal drugs with my marijuana, including cocaine, crack, amphetamines (speed, crystal meth, ecstasy) and hallucinogens (LSD, mushrooms, PCP).

Monitoring

24. I agree to submit to witnessed urine/saliva or blood specimens at any time that my physician requests and give my permission for them to be tested for alcohol and other drugs.

25. I agree to make appointments with my physician, at his/her office in person, at the time of renewal of my medical marijuana treatment.

26. I agree to attend all appointments that my doctor makes for me for tests, assessments and treatment with other healthcare workers, such as pharmacists, other doctors, physiotherapists, psychologists, addiction counselors, etc. I consent to open communication between my doctor and any other healthcare professional involved in my healthcare.

Prescription Termination

27. I agree to attend all requested follow-up visits with my doctor to monitor my marijuana use and I understand that failure to do so could result in the discontinuation of my marijuana treatment.

28. I understand there is a risk of becoming addicted to marijuana. This means I might become psychologically dependent on marijuana, using it to alter my mood or get high. I may be unable to control my use of it. People with a past history of alcohol or drug problems are more susceptible to addiction. If this occurs, my marijuana prescription will be discontinued and I will be referred to a drug treatment program for help with this problem.

29. I understand that violent behavior or threats toward my physician, the staff or other patients is illegal and is not allowed. If this happens, my physician may stop prescribing medical marijuana to me. I may be asked to leave the office, and the police shall be called. (In addition, my physician may decide to stop providing me medical care altogether.)

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30. If I violate this agreement, I understand that my physician may discontinue my marijuana treatment (and my physician may decide to stop providing me with medical care altogether.)

31. I also understand that a physician/patient relationship does not exist. The office visit is solely to recommend medical marijuana.

32. The office of Dr. Hernandez (CANN MED, PC) is not responsible for the retention of my medical records. I also understand that I will be responsible to provide my updated medical record at every visit.

I have read the above agreement and understand it. I have had the opportunity to ask any questions I have regarding medical marijuana and its use, in particular to my health condition. My concerns and questions have been addressed to my satisfaction by my physician.

Prescriber/ Physician's signature: _____

Patient's signature: _____

Date: _____

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FOR OFFICE USE ONLY:

Patient: _____ DOB: _____

Photo ID Copied: _____ yes _____ No

~~Medical Record on File:~~ _____ ~~yes~~ _____ ~~No~~

Date of patient's consultation: _____

Length of time patient has been under practitioners continuing care: _____ more than a year

____less than a year

Treatment period for this certification: _____ One year from date of patient consultation

_____ A treatment period less than one year (please specify)

3 months 6 months 9 months

Serious Medical Conditions under Act 16 (select all that apply; can be more than one)

o Amyotrophic Lateral Sclerosis	o Autism
o Cancer , including remission	o Crohn's Disease
o Sickle Cell Anemia	o Severe Chronic or intractable pain
o Glaucoma	o Epilepsy
o Dyskinetic and spastic disorder	o Terminal Illness
o Neurodegenerative disease	o PTSD
o Huntington Disease	o HIV/AIDS
o Intractable seizures	o Inflammatory Bowel Disease
o Neuropathies	o Multiple Sclerosis
o	o Parkinson's Disease
o Opioid use disorder for which conventional therapeutic interventions are contraindicated or ineffective, or for which adjunctive therapy is indicated in combination with primary therapeutics	o Damage to the nervous tissue of the central nervous system with objective neurological indication of intractable spasticity and other associated neuropathies

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Caregiver Designation: (*only if applicable to you*)

_____The patient is under 18 years of age.

_____The patient needs assistance from a parent, spouse, caregiver, or legal guardian to obtain medical marijuana due to their medical condition.

_____The patient, in the opinions of the practitioner; is either homebound or an inpatient and will not be able to visit a dispensary during the treatment period listed in this patient certification.

_____None of the above.

Caregiver Information (the patient is permitted to designate up to 2 caregivers)

Caregiver #1

Name: _____

Email Address: _____

Telephone Number: _____

Relationship to patient:

_____ Caregiver _____ Custodial Parent _____ Legal guardian _____ Spouse

Caregiver #2

Name: _____

Email Address: _____

Telephone Number: _____

Relationship to patient: _____ Caregiver _____ Custodial Parent_____ Legal guardian _____ Spouse

Practioner Recommendation:

Are there any limitations or restrictions as to the form of medical marijuana for the above patient?

____ No ____ Yes (If yes, please detail below)

_____

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The following form of medical marijuana is recommended for the patient:

____ Vaporizer or nebulizer form

____ Topical Form

____ Liquid

____ Oil

____ Pill

____ Tincture

____ Yes, I recommend that the patient discuss the form of medical marijuana to be dispensed with a medical professional employed by dispensary.

____ Any other information about the above patient's medical condition that should be considered when dispensing medical marijuana?

_____

_____

_____

_____

_____

Dr. Hernandez Signature: _____

Date: _____