MONTANA DEPARTMENT OF REVENUE

Cannabis Control Division
Physician Statement for a
Debilitating Medical Condition for Minors

PSDMC-Minor
V4 5/2022
Clear Form

Minor registered cardholder applicants with a debilitating medical condition must use this form when applying for a Cannabis Control Division card. 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 This 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, unless the physician in Part A is a licensed oncologist, neurologist, or epileptologist (16-12-508(4), MCA).
- A minor patient application is also required with this form. Patients should navigate to the Department of Revenue Transaction Portal (TAP) at https://tap.dor.mt.gov to submit their application.
- The Physician Statement must be submitted with the patient application within 60 days of the date of the physician's assessment. Registry Identification cards will be issued based on the date of application approval for the time period specified by the physician on page 3. Physician statements submitted more than 60 days after the date of assessment will not be accepted.

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: _____

If applicable, indicate if the physician is a ☐ neurologist ☐ oncologist ☐ epileptologist

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

Physical Address of Patient Assessment: _____

Physician Mailing Address, City, State, ZIP: _____

Physician's Telephone Number: _____

Initial 1 or 2 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, including 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. (16-12-509 (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.
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 16-12-509 (2)(j), MCA:

_____

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 16-12-503(6), MCA, 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 time period.

This patient assessment was conducted via telemedicine in accordance with 16-12-502(2), (3) and 16-12-509(2)(d), (4), MCA.

☐ 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 the patient for this recommendation.

c. Having completed a full assessment of the patient's medical history and current condition, and as a result of the medical care and supervision I have provided, I verify that 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 any 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 that 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: _____

Questions? Call us at (406) 444-6900, or Montana Relay at 711 for the hearing impaired.

Part C:
A second physician must complete the following, after performing a physical examination of the minor patient. The second physician is not required if the treating or referral physician from Part A is a neurologist, oncologist, or epileptologist.

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: _____

Second Physical Address of Patient Assessment: _____

Second Physician Mailing Address, City, State, ZIP: _____

Second Physician's Telephone Number: _____

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: _____

Questions? Call us at (406) 444-6900, or Montana Relay at 711 for the hearing impaired.

Please give the completed original form to the patient