Bulletproof Medical Record For Cannabis Authorization

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Faculty / Presenter Disclosure

- **Faculty:** Alan Bell MD FCFP
- **Relationships with commercial and non-commercial interests:**
- **Grants/Research Support:** Amgen, Bristol Myers Squibb, Janssen, Takeda, AstraZeneca, Novartis, Pfizer, Bayer, Lilly, Boehringer Ingelheim, Sanofi, Valeant
- **Speakers Bureau/Honoraria:** Canopy, Amgen, Bristol Myers Squibb, Janssen, AstraZeneca, Servier, Novartis, Pfizer, Bayer, Lilly, Boehringer Ingelheim, Sanofi, Valeant
- **Consulting Fees:** Canopy, Amgen, Bristol Myers Squibb, Janssen, AstraZeneca, Novartis, Pfizer, Servier, Bayer, Lilly, Boehringer Ingelheim, Sanofi, Valeant
- **Patents:** - none
- **Other:** Canadian Cardiovascular Society, Thrombosis Canada, Hypertension Canada, Heart and Stroke Canada

Disclosure of Financial Support

- This program has not received financial support from any commercial or non-commercial organizations

- **Potential for conflict(s) of interest:**
  - Dr. Alan Bell has received payments from Canopy Growth Corporation

Mitigating Potential Bias

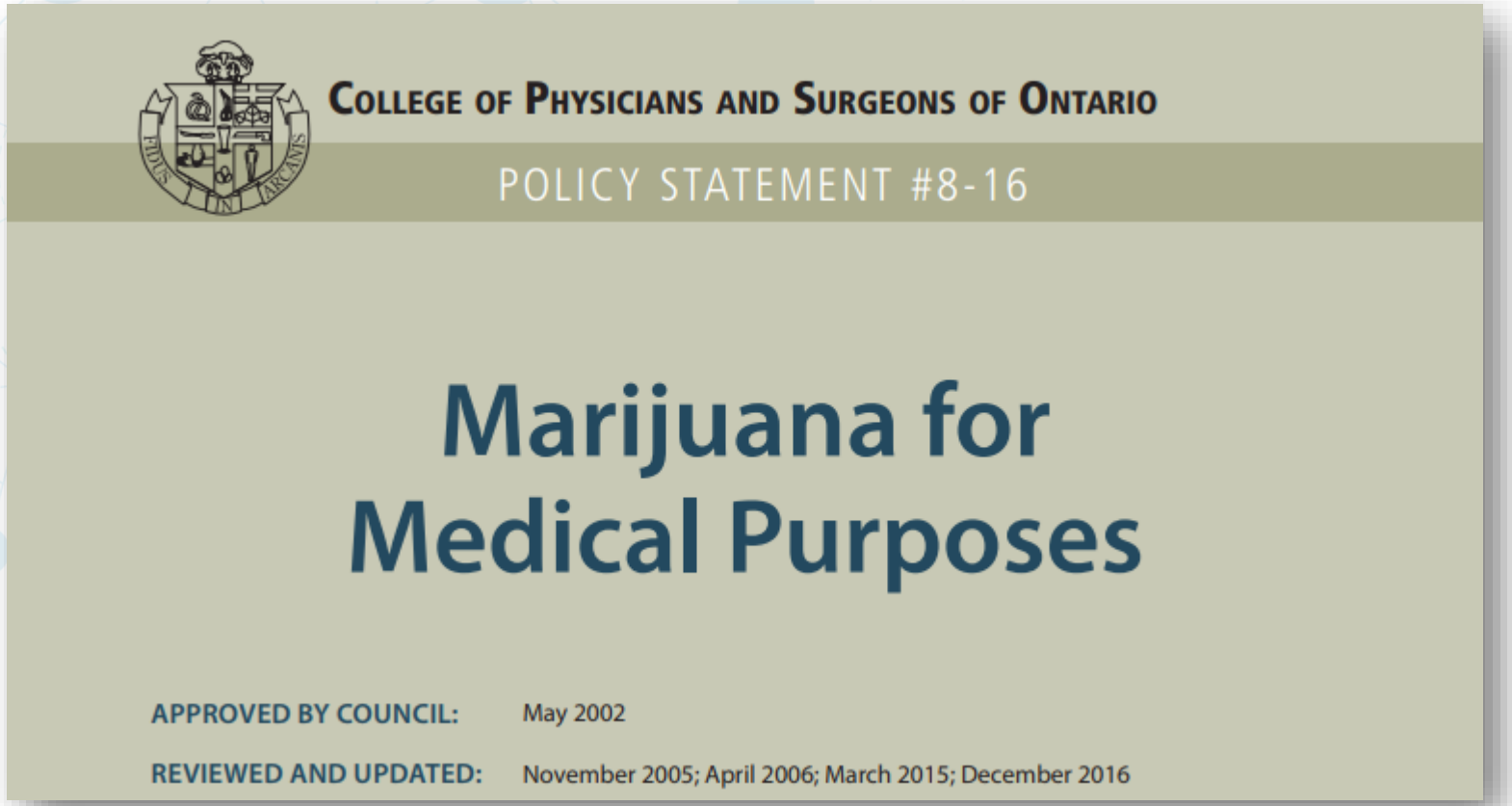
- All program content was developed by the speaker
- No commercial or other non-commercial organization has had any input to the content of this program

Objectives

At the completion of this program participants will:

- Understand the expectations of the College of Physicians and Surgeons of Ontario regarding documentation for authorization of cannabis
- Have a complete resource for ensuring adequate documentation when authorizing cannabis

CPSO Principles



COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

POLICY STATEMENT #8-16

Marijuana for Medical Purposes

APPROVED BY COUNCIL: May 2002

REVIEWED AND UPDATED: November 2005; April 2006; March 2015; December 2016

CPSO Principles

1. Assess the appropriateness of marijuana for the patient
   - Consider other treatment options including the oral and buccal pharmaceutical form
   - Consider risks including, addiction and onset or exacerbation of mental illness and, when smoked, symptoms of chronic bronchitis
2. Obtain consent
   - Advise patients about the material risks and benefits
   - Caution all patients who engage in activities that require mental alertness
   - Explain to the patient the extent and quality of the evidence

CPSO Principles

3. Determining a safe and effective dose
   - Initiate treatment with a low quantity of cannabis
   - Specify the quantity of cannabis to be dispensed
4. Address the risk of abuse, misuse and diversion, similarly to how other controlled substances are managed
   - Patients are required to sign a written treatment agreement

How can this be managed in a busy practice?

With the use of an EMR template containing all essential elements

- Composed of 3 sections
  - Section 1 – Initial visit SOAP note
  - Section 2 – Follow up visits SOAP note
  - Section 3 – Clinical tools
- Electronic Version available for upload to Telus Practice Solutions
- PDF Version available for desktop to complete and insert in patient record for other EMRs

Initial Visit SOAP Note

TELUS Practice Solutions Version

Subjective

Apr 23, 2018 AB

S:

For consideration of authorization of medical cannabis. Potential indication for use of cannabis is •

Patient is «not» cannabis naïve. «Current use « » «vaporizer bowls» «marijuana cigarettes» / day»

Patient has suffered from «chronic «neuropathic» «cancer associate» «fibromyalgia» «post traumatic» «other – specify» pain»

««HIV» «Cancer» associated anorexia and weight loss»

««Muscle spasm» «and» «pain» associated with multiple sclerosis»

«Crohn's Disease»

«Other – insert condition for which patient is seeking authorization for cannabis»

for « » «years» «months».

«If patient is being treated for pain complete this section»

«If not previously well documented insert patients subjective description of pain»

Specify Indication and Duration

Specify Prior Use

Adequately describe symptom

Subjective

Prior Pain Management Therapy

«**Physical Modality**
«Physio» «Chiropratic» «Home Exercise» «Alternative»
Response: *«Partial» «None»*, ***Tolerability:*** *«Good» «Poor»*, ***Continuing:*** *«Yes»«No»»*

«**Psychotherapy**
Response: *«Partial»«None»*, ***Tolerability:*** *«Good»«Poor»*, ***Continuing:*** *«Yes»«No»»*

«**Tricyclic Antidepresant** «specify drug and current dose»
Response: *«Partial»«None»*, ***Tolerability:*** *«Good»«Poor»*, ***Continuing:*** *«Yes»«No»»*

«**SSRI/SNRI** «specify drug and current dose»
Response: *«Partial»«None»*, ***Tolerability:*** *«Good»«Poor»*, ***Continuing:*** *«Yes»«No»»*

««**Gabapentin**» «**Pregabalin**» «specify dose»
Response: *«Partial»«None»*, ***Tolerability:*** *«Good»«Poor»*, ***Continuing:*** *«Yes»«No»»*

«**IR Opiod** «specify drug and current dose»
Response: *«Partial»«None»*, ***Tolerability:*** *«Good»«Poor»*, ***Continuing:*** *«Yes»«No»»*

«**CR Opiod** «specify drug and current dose»
Response: *«Partial»«None»*, ***Tolerability:*** *«Good»«Poor»*, ***Continuing:*** *«Yes»«No»»*

«**Other** «specify drug and current dose»
Response: *«Partial»«None»*, ***Tolerability:*** *«Good»«Poor»*, ***Continuing:*** *«Yes»«No»»*

«If patient is being treated for non-pain indication complete this section»

«Insert description of condition and temporal course of disease for which patient is being treated with marijuana»

Describe prior treatment modalities and response

If non-pain indication provide description

Objective

O:

«If not previously documented insert results of current physical exam
laboratory findings, imaging studies and other objective findings if ap

«SEE ABUSE RISK TOOL BELOW»

Urine drug screen: ««Yes» «date»» «No» «ordered today»

««-ve» «+ve» for cannabis»

««-ve» «+ve» for opiates»

«««-ve» «+ve» for other drugs of abuse» «specify»»

«If patient is being treated for pain complete this section»

«SEE BRIEF PAIN INVENTORY BELOW»
«SEE VAS PAIN SCALE BELOW»

Include physical exam, lab and imaging

Document objective abuse risk assessment

Do urine drugs of abuse screen

Document objective pain assessment

Assessment

A:

Patient suffering from «•» not «tolerant of» «adequately responsive to» prior treatments

Patient has been screened for the following risk factors for use of medical cannabis:

Under age 18 - 25: «Yes»«No»
Severe vascular disease: «Yes»«No»
Respiratory disease: «Yes»«No»
Schizophrenia or Bipolar Disorder: «Yes»«No»
History of alcohol or substance abuse: «Yes»«No»
Concomitant use of hypnotics, or other psychoactive drugs: «Ye
Occupational hazard: «Yes»«No»
Pregnancy and lactation: «Yes»«No»
History of cannabis abuse, alcoholism or drug addiction: «Yes»«No»

Patient is appropriate candidate for authorization of medical cannabis «Yes»«No»

Document summary of rationale for use

Screen for risk of harm

Document decision regarding authorization

Plan

P:

Rationale for use of inhaled vs oral or mucosal cannabinoid:

«patient preference,» «agreed not to smoke marijuana and to «purchase»
«use existing» vaporizer,» «patient requires rapid effect,» «prolonged effect not desirable»

Oral ingestion of cannabis discussed specifically regarding oils and ca
precise and reproducible dosing emphasized

««Cannabis «•» grams/day x «•» days» authorized»

«Cannabis authorization refused»

Follow up in clinic • «weeks» «month«s»»

«SEE PATIENT AGREEMENT FOR CANNABIS THERAPY»
«SEE HEALTH CANADA MEDICAL DOCUMENT»

If inhaled is being authorized specify rationale vs oral or mucosal

Document that smoking is discouraged

Document quantity and duration of Rx

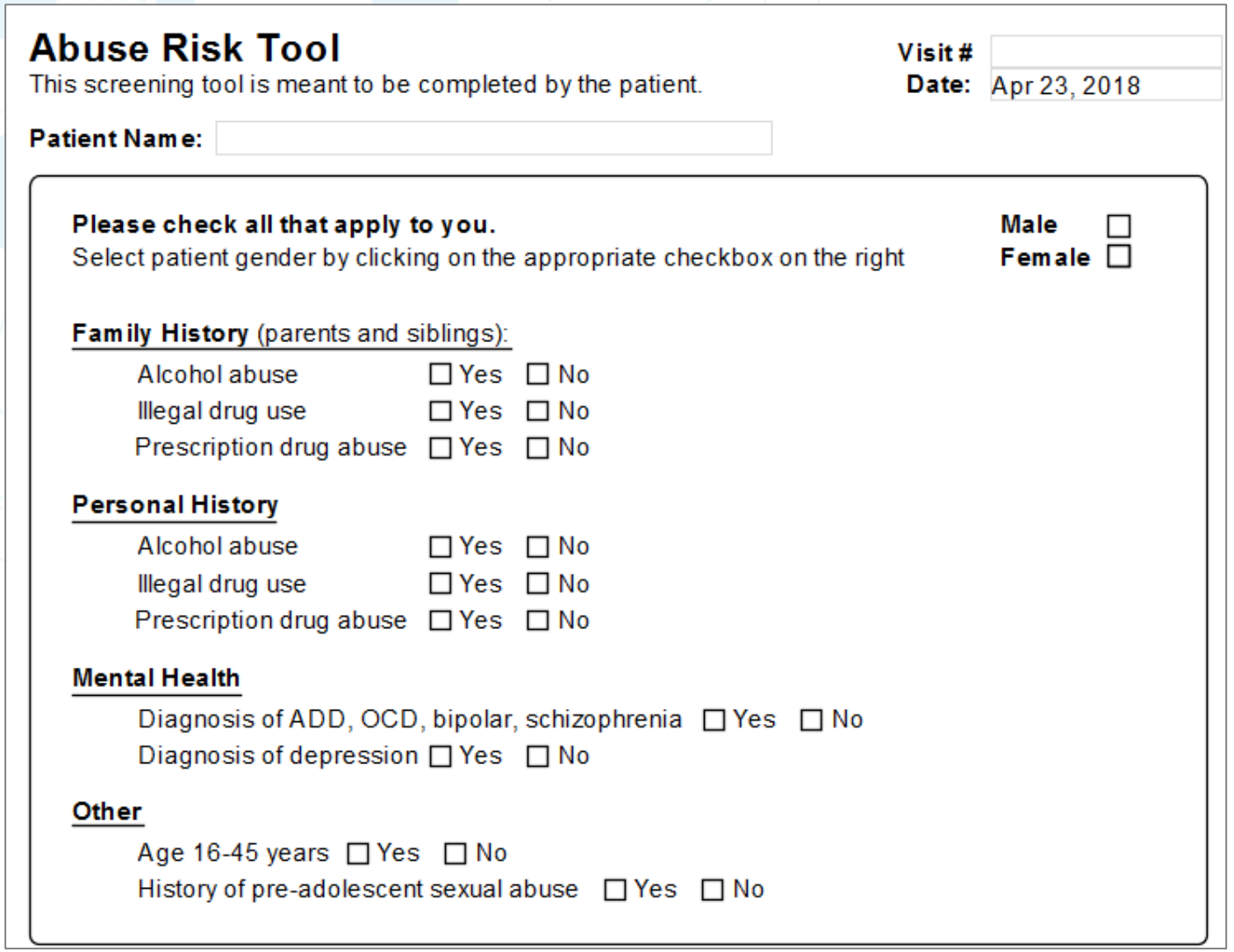
Specify follow up

Complete patient agreement

Clinical Tools

Telus Practice Solutions Version

Abuse Risk Tool



Abuse Risk Tool

This screening tool is meant to be completed by the patient.

Visit #

Date: Apr 23, 2018

Patient Name:

Please check all that apply to you.
Select patient gender by clicking on the appropriate checkbox on the right

Male ☐
Female ☐

Family History (parents and siblings):

- Alcohol abuse ☐ Yes ☐ No
- Illegal drug use ☐ Yes ☐ No
- Prescription drug abuse ☐ Yes ☐ No

Personal History

- Alcohol abuse ☐ Yes ☐ No
- Illegal drug use ☐ Yes ☐ No
- Prescription drug abuse ☐ Yes ☐ No

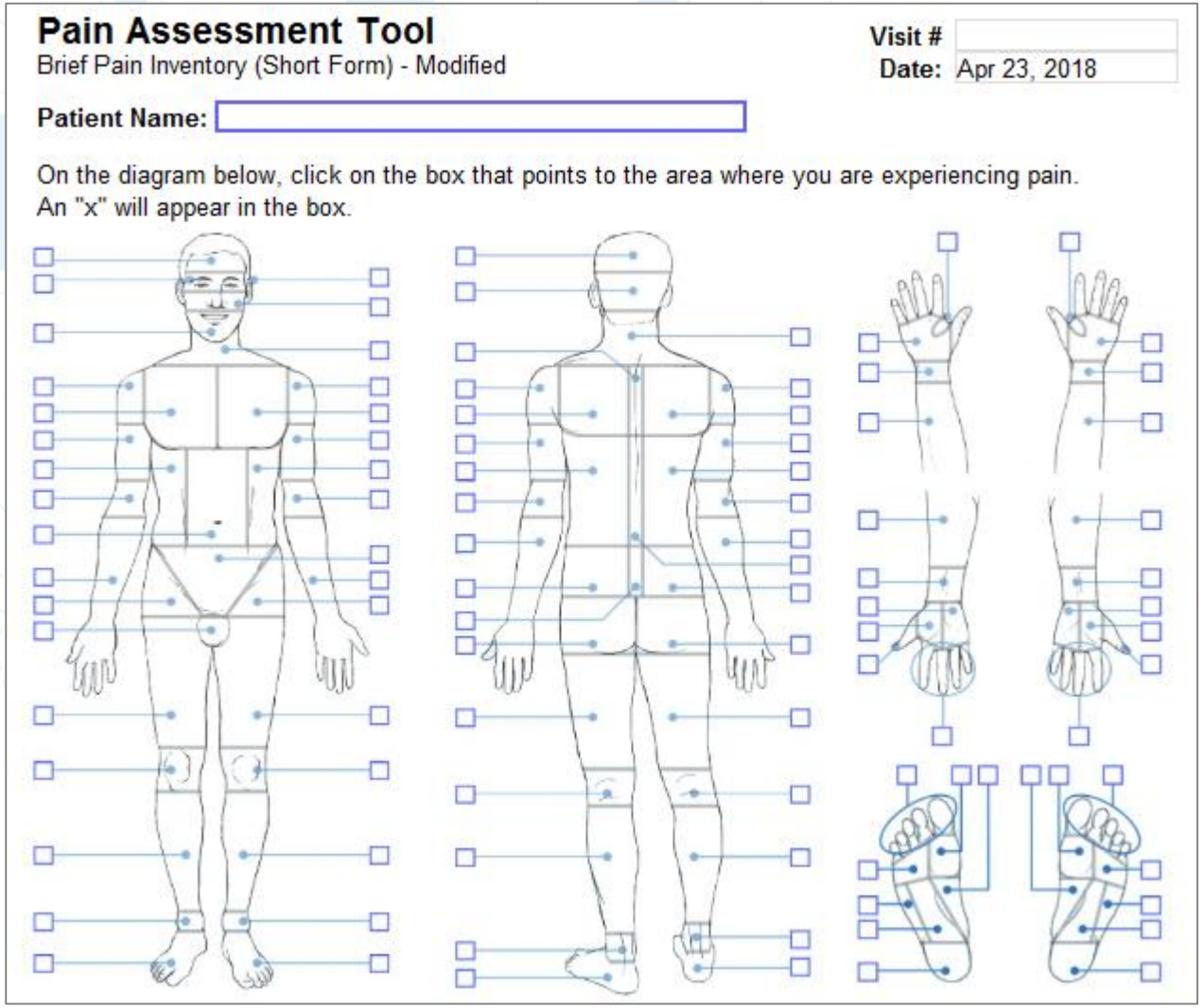
Mental Health

- Diagnosis of ADD, OCD, bipolar, schizophrenia ☐ Yes ☐ No
- Diagnosis of depression ☐ Yes ☐ No

Other

- Age 16-45 years ☐ Yes ☐ No
- History of pre-adolescent sexual abuse ☐ Yes ☐ No

Pain Assessment Tool



Pain Assessment Tool

Brief Pain Inventory (Short Form) - Modified

Visit #

Date: Apr 23, 2018

Patient Name:

On the diagram below, click on the box that points to the area where you are experiencing pain.
An "x" will appear in the box.

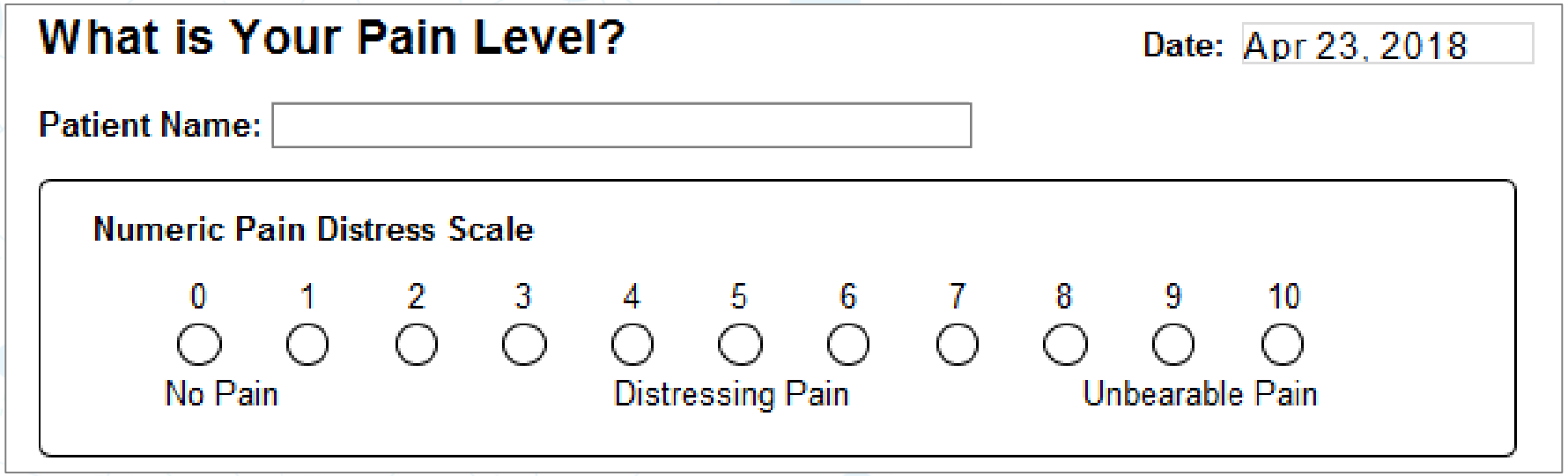
Interference Tool

Select the one number that describes how, during the past week, pain has intefered with your:

A. General activity:	0	E. Relations with other people:	0
B. Mood:	0	F. Sleep:	0
C. Walking ability:	0	G. Enjoyment of life:	0
D. Normal work: (includes both work outside the home and housework)	0		

Interference Scale total score: 0 / 70

Visual Analog Scale (VAS)



Patient Agreement (1)

Patient Agreement for Marijuana Therapy

I understand that I am receiving authorization for medical marijuana from Dr. Alan Bell to treat _____ . Marijuana is being used due to failure of other treatment methods because those other treatments did not help or were associated with intolerable side effects.

I agree to the following:

☐ 1. I will not seek marijuana from another physician. Only Dr. Alan Bell will authorize marijuana for me.

☐ 2. I will not take marijuana in larger amounts or more frequently than is prescribed by Dr. Alan Bell

☐ 3. I will not give or sell my medication to anyone else, including family members; nor will I accept any marijuana from anyone else.

☐ 4. I will not use or seek marijuana from any other legal or illegal sources

☐ 5. I understand that if my authorization runs out early for any reason (for example, if I lose the marijuana, or take more than authorized), Dr. Alan Bell will not authorize extra marijuana for me; wait until the next authorization is due.

☐ 6. I will obtain my marijuana at one licensed grower of my choice; Licensed grower name:

☐ 7. I will store my marijuana in a secured location that will not allow access to any non-authorized persons and safe from access to children

☐ 8. I will not use marijuana if I know or suspect that I am pregnant, or if I am breast feeding.

Patient Agreement (2)

Further,

☐ I understand that the common side effects of marijuana therapy include:

- Heart palpitations and potentially serious abnormal heart beat rhythms
- Fainting
- Flushing
- Dry mouth
- **Constipation**
- Worsening anxiety or depression

☐ I understand that rarely, but potentially serious side effects include:

- Heart attack
- Stroke
- Severe episodic mental illness (psychosis)
- Hepatitis
- Pancreatitis
- Reduced sperm count and fertility
- Addiction

☐ I understand that marijuana will impair my ability to think, concentrate, act and reason. I agree to not partake in any activity, within 8 hours of use, that is potentially dangerous to myse or others including, but not limited to:

- Driving a motor vehicle
- Operating machinery
- Working at heights
- Engage in potentially dangerous recreational activity eg. Skiing, cycling

Patient Agreement (3)

☐ I understand that although marijuana is not a medication approved by Health Canada for tl treatment of any specific condition, limited, published, professionally reviewed evidence exist to support the use of marijuana to assist in the medical management of:

- Neuropathic pain (pain due to nerve injury)
- Chronic non-specific pain
- Weight loss due to HIV / AIDS
- Pain and muscle spasm associated with multiple sclerosis
- Crohn's Disease

☐ I understand that evidence does not exist to demonstrate the benefit of marijuana in th treatment of conditions not listed above.

☐ I understand that the use of any mood-modifying substance, such as tranquilizers, sleeping pills, alcohol or illicit drugs (such as cocaine, opiates or hallucinogens), can cause adverse effect or interfere with therapy. Therefore I agree to refrain from the use of all of these substances.

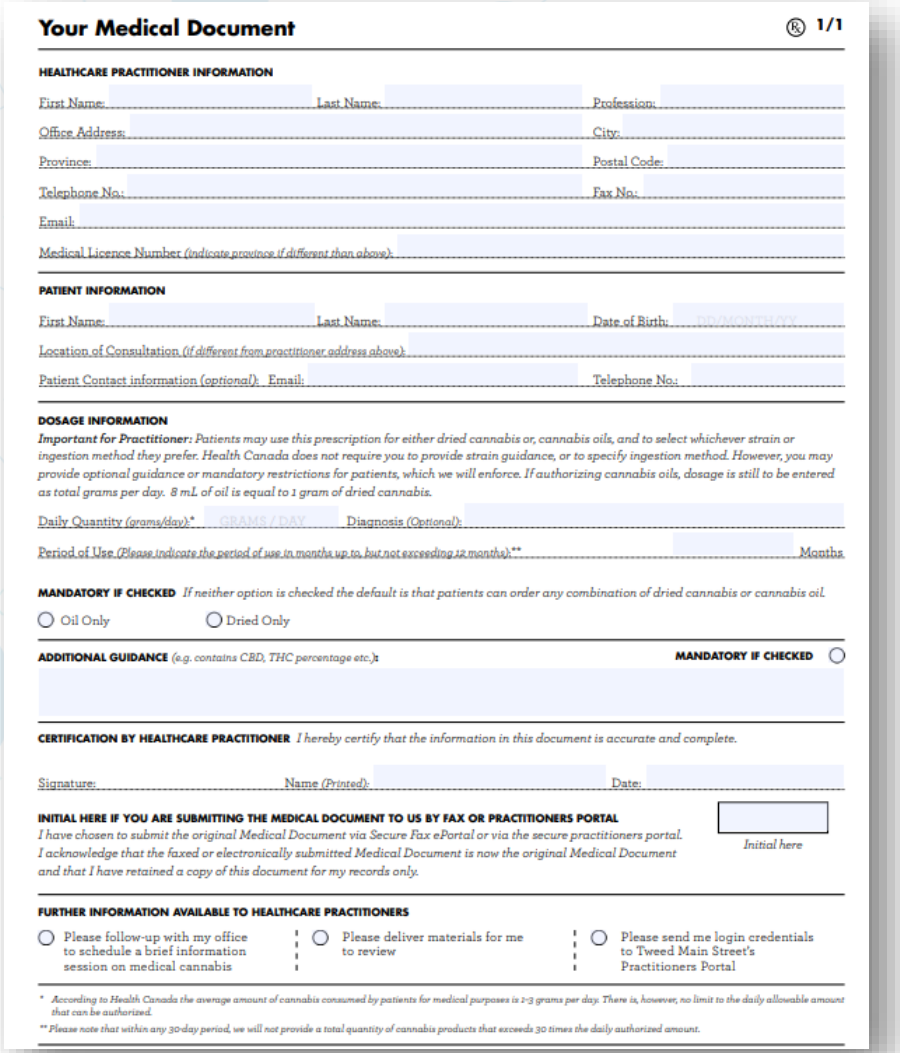
☐ I understand that if I break these conditions, Dr. _____Alan Bell_____ may choose to cease writing marijuana authorization for me.

Patient Signature

Physician Signature

Date
April 23, 2018

Medical Document



Your Medical Document

℞ 1/1

HEALTHCARE PRACTITIONER INFORMATION

First Name: Last Name: Profession:

Office Address: City:

Province: Postal Code:

Telephone No.: Fax No.:

Email:

Medical Licence Number *(indicate province if different than above)*:

PATIENT INFORMATION

First Name: Last Name: Date of Birth: DD/MONTH/YYYY

Location of Consultation *(if different from practitioner address above)*:

Patient Contact information *(optional)*: Email: Telephone No.:

DOSAGE INFORMATION

Important for Practitioner: *Patients may use this prescription for either dried cannabis or, cannabis oils, and to select whichever strain or ingestion method they prefer. Health Canada does not require you to provide strain guidance, or to specify ingestion method. However, you may provide optional guidance or mandatory restrictions for patients, which we will enforce. If authorizing cannabis oils, dosage is still to be entered as total grams per day. 8 mL of oil is equal to 1 gram of dried cannabis.*

Daily Quantity *(grams/day)*:* GRAMS / DAY Diagnosis *(Optional)*:

Period of Use *(Please indicate the period of use in months up to, but not exceeding 12 months)*:** Months

MANDATORY IF CHECKED *If neither option is checked the default is that patients can order any combination of dried cannabis or cannabis oil.*

◯ Oil Only ◯ Dried Only

ADDITIONAL GUIDANCE *(e.g. contains CBD, THC percentage etc.)*: **MANDATORY IF CHECKED** ◯

CERTIFICATION BY HEALTHCARE PRACTITIONER *I hereby certify that the information in this document is accurate and complete.*

Signature: Name *(Printed)*: Date:

INITIAL HERE IF YOU ARE SUBMITTING THE MEDICAL DOCUMENT TO US BY FAX OR PRACTITIONERS PORTAL

I have chosen to submit the original Medical Document via Secure Fax ePortal or via the secure practitioners portal. I acknowledge that the faxed or electronically submitted Medical Document is now the original Medical Document and that I have retained a copy of this document for my records only.

Initial here

FURTHER INFORMATION AVAILABLE TO HEALTHCARE PRACTITIONERS

◯ Please follow-up with my office to schedule a brief information session on medical cannabis

◯ Please deliver materials for me to review

◯ Please send me login credentials to Tweed Main Street's Practitioners Portal

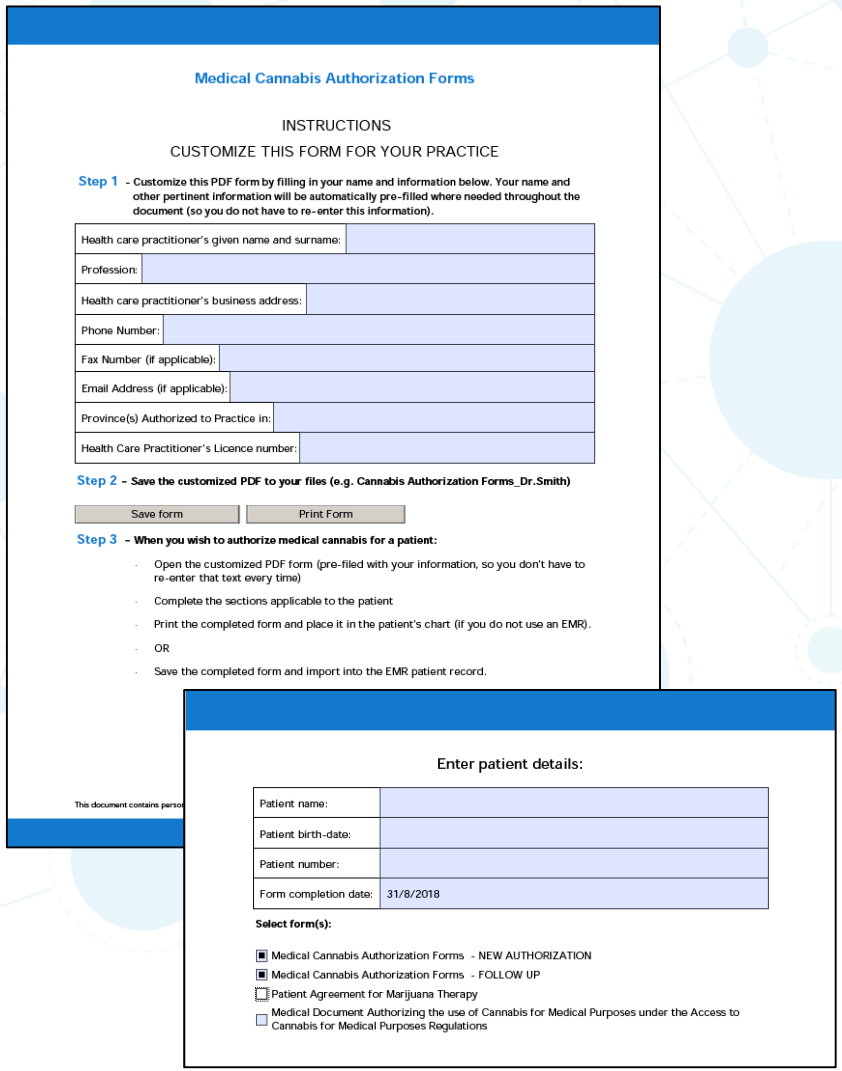
* *According to Health Canada the average amount of cannabis consumed by patients for medical purposes is 1-3 grams per day. There is, however, no limit to the daily allowable amount that can be authorized.*

** *Please note that within any 30-day period, we will not provide a total quantity of cannabis products that exceeds 30 times the daily authorized amount.*

PDF Version

For other EMR systems

PDF Form



Medical Cannabis Authorization Forms

INSTRUCTIONS

CUSTOMIZE THIS FORM FOR YOUR PRACTICE

Step 1 - **Customize this PDF form by filling in your name and information below. Your name and other pertinent information will be automatically pre-filled where needed throughout the document (so you do not have to re-enter this information).**

Health care practitioner's given name and surname:	
Profession:	
Health care practitioner's business address:	
Phone Number:	
Fax Number (if applicable):	
Email Address (if applicable):	
Province(s) Authorized to Practice in:	
Health Care Practitioner's Licence number:	

Step 2 - **Save the customized PDF to your files (e.g. Cannabis Authorization Forms_Dr.Smith)**

Save form | Print Form

Step 3 - **When you wish to authorize medical cannabis for a patient:**

- Open the customized PDF form (pre-filed with your information, so you don't have to re-enter that text every time)
- Complete the sections applicable to the patient
- Print the completed form and place it in the patient's chart (if you do not use an EMR).
- OR
- Save the completed form and import into the EMR patient record.

This document contains perso

Enter patient details:

Patient name:	
Patient birth-date:	
Patient number:	
Form completion date:	31/8/2018

Select form(s):

- [x] Medical Cannabis Authorization Forms - NEW AUTHORIZATION
- [x] Medical Cannabis Authorization Forms - FOLLOW UP
- [ ] Patient Agreement for Marijuana Therapy
- [ ] Medical Document Authorizing the use of Cannabis for Medical Purposes under the Access to Cannabis for Medical Purposes Regulations

Step 1 – Customize this PDF form by filling in your name and information below.

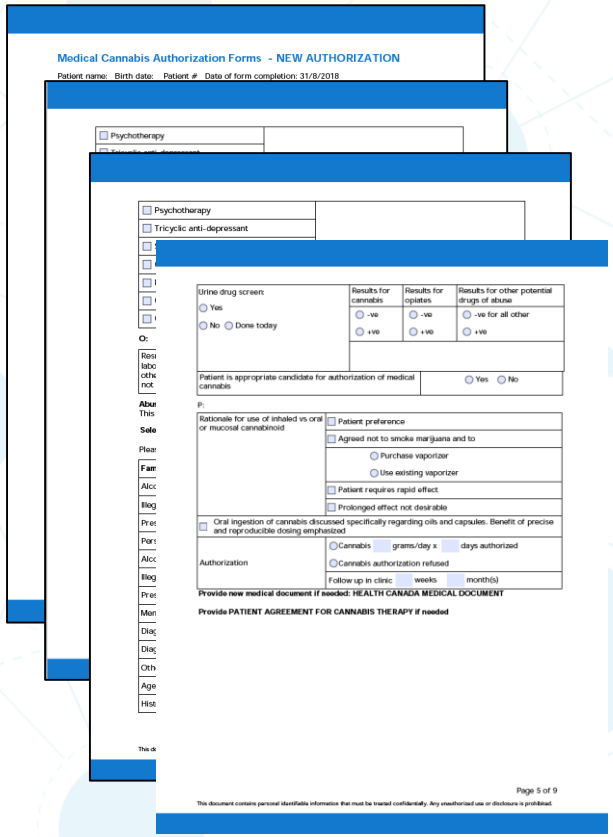
- Information will be automatically saved and pre-filled throughout the document

Step 2 - Save the customized PDF to your files

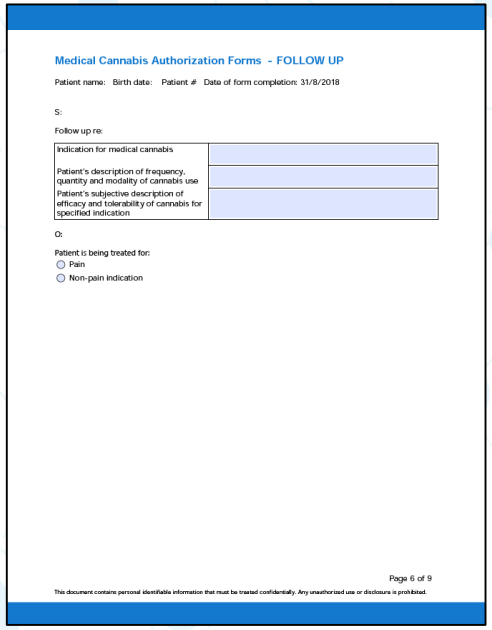
Step 3 – When you wish to authorize medical cannabis for a patient:

- Open the pre-saved customized PDF form
- Complete the sections applicable to the patient
- Print the completed form and place it in the patient's chart or;
- Save the completed form and import into the EMR patient record.

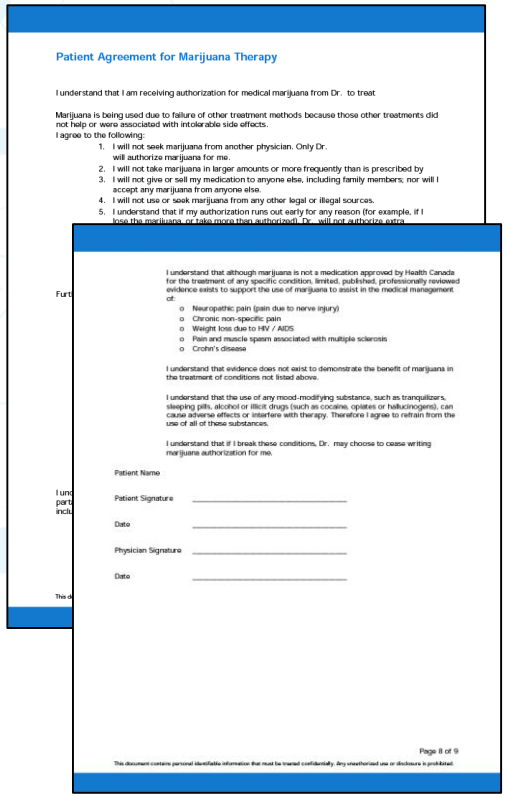
PDF Form



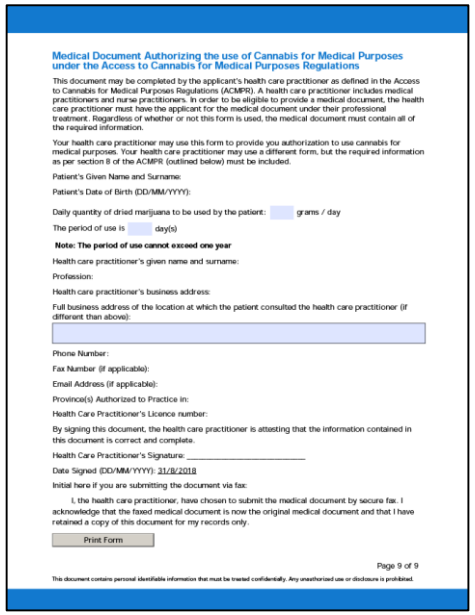
Medical Cannabis Authorization Forms
NEW AUTHORIZATION



Medical Cannabis Authorization Forms
FOLLOW UP



Patient Agreement for Marijuana Therapy



Medical Document Authorizing the use of Cannabis for Medical Purposes under the Access to Cannabis for Medical Purposes Regulations

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Activity ID: 540042 CPSO#: 32472

March 28, 2018

PRIVATE & CONFIDENTIAL

Dr. Alan David Bell
7 Elizabeth St
Thornhill, ON L4J 1X7

Dear Dr. Bell:

Dr. Bell has a very high-quality practice. Within the constraints of a busy practice ALL required elements of charting are present and satisfied. I cannot really fault ANY of his charting. Histories, Physical Examinations and Psychosocial visits are well documented. Mental status examinations are documented where appropriate. Diabetic Flow sheets are used and kept up-to-date. (many offices do not chart all elements in the Diabetic Flow Sheet. Dr. Bell does.) Cumulative Patient Profiles are kept Up-to-date. Well baby visits are complete and the 18 month visit is performed as recommended. (only 50% of Primary Care offices in Toronto perform the 18 month visit as recommended). In Obstetrics patients the Ontario Antenatal record is completed as recommended and includes all of the suggested elements.

Care demonstrated is excellent. Diagnoses, Investigations, and Management Plans are clear and appropriate. Recommended preventive screening rates are very high. Follow-up and Monitoring are excellent.

Cannabis Authorization Chart Templates
PDF and Telus PS Files Download

https://sites.google.com/fusionmd.ca/bulletproofyourpractice

Click Here or Here to Download

Slide courtesy of A Bell MD

Resources

Health Canada

- Information for Health Care Professionals Cannabis (marihuana, marijuana) and the cannabinoids
  http://www.hc-sc.gc.ca/dhp-mps/alt_formats/pdf/marihuana/med/infoprof-eng.pdf

College of Physicians and Surgeons of Ontario

- Policy Statement: Marijuana for Medical Purposes
  http://www.cpso.on.ca/policies-publications/policy/medical-marijuana

College of Family Physicians of Canada

- Authorizing Dried Cannabis for Chronic Pain or Anxiety – preliminary guidance
  http://www.cfpc.ca/Dried_Cannabis_Prelim_Guidance/

National Academies of Sciences Engineering and Medicine

- The Health Effects of Cannabis and Cannabinoids: The Current State of Evidence and Recommendations for Research 2017
  http://www8.nationalacademies.org/onpinews/newsitem.aspx?RecordID=24625

QUESTIONS?