WorkSafe
Travail sécuritaire NB

Chief Medical Officer
1 Portland Street, P.O. Box 160
Saint John, N.B. E2L 3X9
Phone 506 738-4053
Toll-free 1 800 222-9775
Fax 506 642-0703
Web worksafenb.ca

Médecin-chef
1, rue Portland, case postale 160
Saint John (N.-B.) E2L 3X9
Téléphone 506 738-4053
Sans frais 1 800 222-9775
Télécopieur 506 642-0703
Web travailsecuritairenb.ca

Important Information

Please work through the following pages with your patient or the patient's chart as necessary. Fax completed documents to 1 888 629-4722. Keep the original in your chart / file.

Fee: upon receiving the completed booklet, WorkSafeNB will pay the booklet completion fee equivalent to twice the amount of an office visit fee. Each section must be complete to qualify for reimbursement by WorkSafeNB.

If you do not wish or are unable to complete the booklet and wish to stop after question 1, please submit this completed receipt and pg. 1 of the *WorkSafeNB Cannabis Review Booklet* and WorkSafeNB will pay the administration fee equivalent to 33% of an office visit fee.

THIS DOCUMENT IS YOUR RECEIPT.

☐ I, _____ request full reimbursement for completing the Cannabis Review booklet for my patient, _____.

☐ I, _____ decline to complete the *Cannabis Review Booklet* for my patient, _____. I have completed the administrative questions on the first page of the booklet and am requesting the appropriate reimbursement for administrative fees.

Authorizing (Prescribing) Physician name: _____

Signature: _____

Date: _____

Payee Code: _____

For QUESTIONS on completing this form please contact WorkSafeNB toll-free at 1 877 647-0777.

Please note: The information requested is based upon a reasonable standard of medical practice in the province of New Brunswick. The review process was developed according to the guidelines of WorkSafeNB's Cannabis (Marijuana) for Medical Purposes policy, available online at worksafenb.ca/info/cannabis-policy.

WorkSafeNB Cannabis Review Booklet

(Physician Form – Full Risk Assessment)

AUTHORIZING (PRESCRIBING) PHYSICIAN

This patient's treating physician was unable or unwilling to provide the required supporting information regarding medical authorization of cannabis products. Please provide the following information:

PATIENT INFORMATION

Patient name: _____

Date of birth: _____

Address: _____

Phone number: _____

Claim number: _____

1. Do you wish to participate in WorkSafeNB's Cannabis Review Process by completing this document?

☐ YES: PROCEED TO QUESTION 2.

☐ NO: I recognize WorkSafeNB may conduct an independent medical evaluation to complete the assessment.

STOP HERE.
SUBMIT INVOICE FOR 33% OF AN OFFICE VISIT FEE.

2. What are the **patient's specific symptoms** for which medical authorization for cannabis is being requested (nature and location of symptoms)?

_____

_____

_____

3. To your knowledge, when did the symptoms begin **(YYYY-MM-DD)?**

_____

4. What is the **working diagnosis** responsible for your patient's symptoms?

_____

5. How do you think your patient's symptoms impact his or her functioning in occupational and daily activities?

_____

_____

_____

_____

6. Please list therapies trialed to date for your patient's symptoms and condition(s) identified above:

☐ Unable to answer

Medications trialed (non-cannabinoid) (attach another page if necessary)

Name of drug	Initiation date	Maximum dosage achieved	Beneficial effects	Adverse effects	Reason for discontinuation (if applicable)	Date discon-tinued
i.						
ii.						

iii.						
iv.						
v.						

7. To your knowledge, has your patient tried any pharmaceutical cannabinoid for the above symptom(s) or condition(s), such as nabilone, nabiximols or other synthetic cannabinoid product? Please include the initiation date, maximum dosage achieved, main effects, side effects, reasons for discontinuation, and date of discontinuation if applicable.

Pharmaceutical Cannabinoids Trialed ☐ Unable to answer

Name of cannabinoid	Initiation date	Maximum dosage achieved	Beneficial effects	Adverse effects	Reason for discontinuation (if applicable)	Date discon-tinued
i.						
ii.						
iii.						
iv.						

8. Please list **all current medications** that you know to be prescribed or otherwise medically authorized for your patient, and include the dosage, schedule and indicated condition.
(Please attach another page if more space is required)

All Current Medications

☐ Unable to answer

Name of drug	Dosage	Schedule	Indicated condition
i.			
ii.			
iii.			
iv.			
v.			

9. To your knowledge, was your patient using cannabis prior to the work injury or onset of the condition for which he or she has a WorkSafeNB claim?

☐ YES ☐ NO

☐ UNKNOWN

10. **The following information is necessary for risk assessment or potential contraindications.** Please list **ALL past and current medical conditions** of which you are aware for this patient. (Please attach another page if more space is required)

☐ Unable to answer

_____

_____

_____

_____

_____

_____

_____

11. **The following information is necessary for risk assessment or potential contraindications.** Please list **ALL prior surgeries or procedures** of which you are aware for this patient. (Please attach another page if more space is required)

☐ Unable to answer

_____

_____

_____

_____

_____

_____

12. **The following information is necessary for risk assessment or potential contraindications.** Please list **ALL current and past psychological/psychiatric conditions** of which you are aware for this patient**.** (Please attach another page if more space is required)

☐ Unable to answer

_____

_____

_____

_____

_____

13. The following information is necessary for risk assessment or potential contraindications. Please list **ALL abnormal physical findings on current examination**, whether related or unrelated to the work injury or condition. Please include any pain or neuropathic findings. (Please attach another page if more space is required)

☐ Unable to answer

_____

_____

_____

_____

_____

_____

14. Does your patient smoke tobacco? ☐ YES ☐ NO ☐ UNKNOWN

If YES, please provide the amount he or she uses per day to the best of your knowledge, as well as how many years he or she has been a regular tobacco user:

_____

_____

15. Does your patient consume alcohol?

If YES, please provide the amount he or she uses per day to the best of your knowledge, as well as how many years he or she has been a regular drinker:

_____

_____

16. To your knowledge, does your patient currently use recreational drugs other than cannabis? ☐ YES ☐ NO ☐ UNKNOWN

If YES, please provide the type(s) of drug that he or she uses and the amount(s) per day to the best of your knowledge, as well as how many years he or she has been a regular substance user:

_____

_____

_____

17. To the best of your knowledge, does your patient have a history of substance use disorder involving a drug other than cannabis? ☐ YES ☐ NO ☐ UNKNOWN

If YES, which substance(s) and describe or give a brief summary.

_____

_____

18. If your patient **does not use cannabis**, please proceed to Question 19.

If your patient uses cannabis, please respond to the following statements to the best of your knowledge. If unknown, leave the question blank.

My patient:

i. Takes cannabis in larger amounts or over a longer period than was intended. ☐ YES ☐ NO

ii. Has persistent desire or unsuccessful efforts to cut down or control cannabis use. ☐ YES ☐ NO

iii. Spends a great deal of time is spent in activities necessary to obtain cannabis, use cannabis, or recover from its effects. ☐ YES ☐ NO

iv. Demonstrates a craving, or a strong desire or urge to use cannabis ☐ YES ☐ NO

v. Uses cannabis despite it resulting in a failure to fulfill major role obligations at work, school, or home. ☐ YES ☐ NO

vi. Uses cannabis despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of cannabis. ☐ YES ☐ NO

vii. Gives up or reduces important social, occupational, or recreational activities because of cannabis use. ☐ YES ☐ NO

viii. Uses cannabis in situations where it is physically hazardous. ☐ YES ☐ NO

ix. Continues using cannabis despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by cannabis. ☐ YES ☐ NO

x. Does your patient show signs of tolerance, as defined by either of the following: ☐ YES ☐ NO

A need for markedly increased amounts of cannabis to achieve intoxication or desired effect. ☐ YES ☐ NO

Markedly diminished effect with continued use of the same amount of cannabis. ☐ YES ☐ NO

xi. Does your patient show signs of withdrawal, as manifested by either of the following: ☐ YES ☐ NO

Three (or more) of the following signs and symptoms develop within approximately one week after cessation of cannabis use (heavy and prolonged: usually daily or almost daily use): ☐ YES ☐ NO

Irritability, anger, or aggression; nervousness or anxiety; sleep difficulty (e.g. insomnia, disturbing dreams); decreased appetite or weight loss; restlessness; depressed mood; at least one of the following physical symptoms causing significant discomfort: abdominal pain, shakiness/tremors, sweating, fever, chills, or headache.

19. Does the following apply to your patient to the best of your knowledge? If unknown, leave the question blank.

i. They are under the age of 25 ☐ YES ☐ NO

ii. They have a personal history or strong family history of psychosis ☐ YES ☐ NO

iii. They have a current or past cannabis use disorder ☐ YES ☐ NO

iv. They have an active substance use disorder ☐ YES ☐ NO

v. They have cardiovascular disease (angina, peripheral vascular disease, cerebrovascular disease, arrhythmias) ☐ YES ☐ NO

vi. They have respiratory disease ☐ YES ☐ NO

vii. She is a woman who is pregnant, planning to become pregnant, or breastfeeding ☐ YES ☐ NO

viii. They have a concurrent active mood or anxiety disorder ☐ YES ☐ NO

ix. They smoke tobacco ☐ YES ☐ NO

x. They have risk factors for cardiovascular disease ☐ YES ☐ NO

xi. They are a heavy user of alcohol or is taking high doses of opioids, benzodiazepines or other sedating medications, whether prescribed or available over the counter ☐ YES ☐ NO

20. In your opinion, does your patient require additional assessment and/or support for psychological condition(s), including issues related to substance misuse? ☐ YES ☐ NO

If YES, please elaborate.

_____

_____

21. Do you have any concerns for your patient regarding side effects and/or adverse events associated with cannabis use (Check one answer for each selection)?

RISKS	NONE	SOME	UNSURE	Unable to evaluate
Medical/psychological side effects				
Cannabis dependence				
Driving impairment				
Ability to perform or function at work				
Ability to meet work site safety standards tasks				

22. What are the specific **functional goals** of treatment using cannabis?

_____

_____

_____

_____

_____

_____

_____

_____

_____

23. Please specify details of the medicinal cannabis authorization (if already provided):

a. This patient has medical authorization for _____/_____ (amount/units) of cannabis product per day for _____ duration.

b. Mode(s) of administration: _____

c. Document reported strain/ oil name/ other product name below:

	Strain/ product name	% THC	% CBD
i.			
ii.			
iii.			

d. Cannabis brand or identifier: _____

e. Licensed producer name: _____