WorkSafe
Travail sécuritaire NB

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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 2, please submit this completed receipt and pg. 1 of the *Monitoring Form for Continued Use of Medicinal Cannabis* 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 *Monitoring Form for Continued Use of Medicinal Cannabis* 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.

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.

MONITORING FORM FOR CONTINUED USE OF MEDICINAL CANNABIS

FAMILY PHYSICIAN/NURSE PRACTITIONER

WorkSafeNB will review injured workers' treatment plans and goals to ensure medicinal cannabis continues to be necessary and effective in treating the compensable injury or disease. We require the primary care provider or the authorizing physician to provide evidence of having followed WorkSafeNB's monitoring requirements.

Patient name: _____

1. Are you this patient's: ☐ Primary Care Provider and/or ☐ Authorizing Physician

2. Do you agree to participate in WorkSafeNB's Cannabis Monitoring requirements by completing this form? ☐ YES ☐ NO

WorkSafeNB first requests monitoring from the primary care provider. If the primary care provider does not agree to monitor the effects of the cannabis authorization, WorkSafeNB requests participation from the authorizing physician. If both care providers do not agree to participate, WorkSafeNB will not support further cannabis authorization as the safety and effectiveness of the treatment cannot be determined.

3. Please specify details of the medicinal cannabis authorization (if already provided):
   a. This patient has medical authorization for _____ grams of marijuana per day for _____ duration.
   b. Mode(s) of administration: _____
   c. Document reported strains below:

	Strain	% THC	% CBD
i.			
ii.			
iii.			

   d. Cannabis brand or identifier: _____
   e. Licensed producer name: _____

4. 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)

Current Medications

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

The following information is necessary for risk assessment or potential contraindications.

5. Please list **any changes in the patient's medical condition** you are aware of. Include all surgeries or procedures within that last year that you are aware of for this patient. (Please attach another page if more space is required)

_____

_____

_____

6. Does your patient smoke tobacco? ☐ YES ☐ NO

If YES, how much and how often? _____

7. Does your patient consume alcohol? ☐ YES ☐ NO

If YES, how much and how often? _____

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

If YES, please provide the substance and quantity: _____

9. Do any of the following apply to your patient to the best of your knowledge? Leave blank if unknown.

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

10. Do you have any concerns for your patient regarding side effects and/or adverse events associated with dried cannabis use?

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				

11. How has your patient's **function changed** since starting medicinal cannabis or since the date of the last review?

_____

_____

12. What are the **revised functional goals** of treatment using cannabis?

_____

_____

Thank you for participating in WorkSafeNB's Cannabis Risk Assessment process.