

Office Cannabis Policy

A clinical and operational policy template for the dental practice

Companion resource to the CE Dojo course “Cannabis & Dentistry.” Fill in the bracketed fields, delete guidance you don’t need, and have your own attorney review the finished policy before you adopt it.

POLICY ADOPTION	
Practice name	[PRACTICE NAME]
Location(s)	[ADDRESS / SITES]
State(s) of operation	[STATE] (cannabis and employment law vary by state)
Designated clinical lead	[DENTIST / OWNER responsible for clinical decisions under this policy]
Effective date	[DATE]
Scheduled review	[DATE] (review at least annually; sooner if your state law changes)

This is a template, not legal advice.

Cannabis law, medical-cannabis certification, and employment law differ by state and change often. This document gives you a clinical framework and sample language. It does not replace advice from your own attorney. Confer with counsel before you refuse to treat a patient, discipline an employee, or adopt a blanket rule about cannabis.

1. Purpose and scope

Organized dentistry has been slow to say how the office should handle the cannabis patient, which leaves each practice to work it out alone. In 2021 the ADA House of Delegates passed a resolution encouraging the development of best practices for managing patients under the influence of marijuana, but it stopped short of clinical guidance, citing limited data ^[1]. That gap is what this policy fills for our office. It sets one standard for how we treat patients who use cannabis, how we protect our team, and how we document what we decide.

The need is not hypothetical. In an ADA survey, 52 percent of dentists reported patients arriving for appointments high, 56 percent said they had limited treatment as a result, and 46 percent had at times increased anesthesia to treat them. In a later ADA report, 46 percent said they were seeing more patients under the influence than a year earlier ^[2].

The policy rests on a single clinical principle: **use is not impairment**. We treat cannabis the way we treat any other centrally acting drug a patient may be taking. We assess the patient in front of us, we act on what we can observe and measure, and we write it down. This tracks the ADA's own position, that cannabis use by itself does not establish incapacity and that a capacity assessment is required ^[3].

Scope: this policy covers patients who disclose cannabis use, patients we suspect have used, and the operational questions that come with them (odor in the reception area, secondhand smoke, vital signs, consent, and staff communication). A separate section addresses employee use.

2. Guiding principle: use is not impairment

A patient can use cannabis and be perfectly fit to treat. A patient can also be impaired. Those are two different findings, and this office keeps them separate.

- **Use** means the patient consumed cannabis at some point. Odor, a positive test, or a medical card all point to use. None of them, on its own, proves the patient is impaired right now.
- **Impairment** means the patient's judgment, coordination, or ability to understand and consent is affected at this moment. That is a clinical read, based on behavior and objective findings.

THC can linger in the body for days or weeks, so a positive test proves exposure, not current impairment. Formal impairment testing is a neuropsychological determination we are not equipped to make chairside. So we document **what we observe** and the clinical decision we made because of it, and we do not label a patient "impaired" on the strength of a smell or a card.

The line that protects the patient and the office

A medical card is not a license to be impaired during care. And use alone is not a reason to refuse care. We assess every cannabis patient the same way: separate use from impairment, then act on what we observe.

3. Health history and the medical cannabis card

We ask every patient about cannabis on the written health questionnaire, in the same neutral way we ask about tobacco and alcohol. This is a drug history, not a judgment.

Add these items to the health questionnaire

- Do you use cannabis (marijuana, THC, or CBD) in any form? **Yes / No**
- If yes, how do you use it? *smoke / vape / edible / tincture / topical / other*
- When did you last use? (date and approximate time)
- Do you hold a medical cannabis card? **Yes / No**. Issuing state: _____
- Do you use CBD products? **Yes / No**. (CBD counts as a drug. It inhibits CYP3A4 and CYP2C19 and can raise levels of medications cleared by those enzymes, the same mechanism as grapefruit juice.)

Treat a medical card as a clinical flag

When a patient reports a card, read it clinically, not legally. It tells you three things at once: **chronic, often daily exposure**; access to higher-potency products than the recreational market allows; and the shifted sedation and cardiac risk that come with heavy use. You would note a daily benzodiazepine. Note the card for the same reason.

Same product, flower to flower, medical and recreational THC run close (roughly 19 versus 21 percent). The difference is what a medical program unlocks: concentrated extracts, tinctures, and high-milligram edibles well above adult-use caps. A cardholder is very plausibly taking in more total THC, in more potent forms, than a recreational user. That is why the card matters at the chair.

4. Odor, the reception area, and secondhand smoke

The patient who brings the smell into the office

Odor is a prompt to investigate. It does not establish impairment, and it is never a reason to confront anyone in a crowded reception area. When staff notice that a patient smells of cannabis:

- **Protect privacy first.** Bring the patient back to an operatory before asking a single question. No conversation about cannabis happens at the front desk or in front of other patients.
- **Ask the routine history.** “We ask everyone this. Have you used cannabis today, and if so, when and how?” You are separating recent use, which the odor suggests, from impairment, which you still have to assess.
- **Never announce it.** Staff do not comment on the smell within earshot of the waiting room. The complaint goes to the treating dentist or designated lead, quietly.

Secondhand smoke is an occupational exposure

A patient who smoked or vaped before walking in can off-gas into a closed reception area. That is a real exposure to our team and to other patients, and it is a fair complaint. Cannabis smoke carries many of the same combustion products as tobacco smoke. We treat staff exposure as a workplace health issue, not an annoyance.

Standing measures for the reception area:

- Keep the reception area ventilated; run air handling or filtration where available.
- Empower any team member to move an off-gassing patient to a private room promptly, both for privacy and to clear the shared air.
- Post the practice’s pre-appointment expectation (below) so patients know before they arrive: *“Please do not use cannabis for at least 24 hours before your visit.”*

- Log repeated exposure complaints so the office can act on a pattern rather than a one-off.

Pre-appointment notice (adapt and post / add to reminders)

“For your safety and the comfort of others, please do not use cannabis (smoked, vaped, or edible) for at least 24 hours before your appointment, and longer if you can. Recent use can affect sedation, your heart rate and blood pressure, and your ability to consent to treatment. If you use cannabis medically, tell us at check-in so we can care for you safely.”

5. Recent use you can’t smell: vape pens and edibles

Odor triggers most of the workflow above, but two common routes give off little or nothing. Odorless vapor pens leave almost no smell, and edibles leave none at all. So a patient can arrive with recent, still-climbing use and no scent to tip you off. This is the blind spot in any odor-based approach, and it needs its own triage.

There is no validated chairside test for cannabis impairment. No breathalyzer equivalent, and no “mini-mental exam” for THC. So you work from several imperfect pointers together, no one of which is proof on its own.

What to weigh when there is no odor

- **The health history, if it is honest.** The questionnaire is your first line, and for the forthcoming patient it settles the question. Its weakness is plain: it only works if the patient answers truthfully, and some will not.
- **Your practice’s base rate, as an index of suspicion.** How common cannabis use is in your patient population sets your prior. A practice that sees a lot of it should carry a higher baseline vigilance for every patient. This raises your overall index of suspicion. It is never a license to single out a patient by appearance, age, or identity.
- **Observable signs of intoxication (below).** When the history is silent, the patient’s presentation is what you have left. Treat signs as prompts to assess further, not as a diagnosis.
- **The oral exam, for chronic use.** The mouth keeps a record the history sometimes hides. A xerostomia-driven caries pattern that does not fit the patient’s hygiene (rampant, cervical, smooth-surface); periodontal breakdown independent of tobacco, with heavy staining that “sets like paint” and gingival enlargement; leukoplakia and chronic mucosal irritation in someone who smokes; and acid erosion (perimylolysis) that raises cannabinoid hyperemesis in a young adult with otherwise sound teeth. These flag a chronic user, not today’s dose, so they raise suspicion rather than prove current impairment. Grab every pointer you can; this is one more.^[4]
- **Vital signs.** An unexplained resting tachycardia in an otherwise well patient is an objective tell that fits recent use, even when nothing is disclosed and nothing is smelled. Check vitals (Section 7) whenever suspicion is up.

Observable signs of intoxication

None of these confirms impairment on its own, and there is no chairside test that does. Read them together, in context:

- Conjunctival injection (red eyes) and heavy or droopy eyelids.
- Resting tachycardia and dry mouth.
- Delayed reactions, short-term memory lapses, difficulty tracking the conversation.

- Slowed or slurred speech and an altered sense of time.
- Euphoria and giddiness, or the opposite: anxiety, paranoia, or agitation.
- Drowsiness or sedation, unsteady coordination, and, with edibles, a patient who drifts deeper as the visit goes on.

Suspicion is not a diagnosis

When the pointers line up (an honest disclosure, a high base rate, signs, or an unexplained tachycardia), raise your vigilance, check vitals, assess capacity to consent, and document what you observed. You are adjusting how carefully you proceed, not accusing the patient. If capacity is in doubt, elective care waits.

6. Chairside screening and the capacity determination

A patient who has used cannabis raises 2 questions, and only 1 of them belongs to a dentist. Whether someone is legally impaired is a determination law enforcement makes, using specially trained examiners and a protocol built for the roadside. Whether this patient can give valid consent, and whether it is safe to layer nitrous, a benzodiazepine, or an opioid on top of what is already on board, is a clinical judgment this office is licensed and obligated to make. We assess the second question and we chart the answer.

Capacity has an accepted clinical standard. A patient with capacity can understand the information, appreciate how it applies to them, reason through the options, and communicate a choice [6]. Every element below feeds that determination. None of them is a test for being high, and this office does not run one.

Odor starts the assessment. It does not decide it.

Odor is what usually puts the office on notice, and in a practice that sees smoked or vaped cannabis it is present more often than not. That makes it the trigger. It is also the weakest piece of information in the whole workflow, because it tells you the route and rough recency and nothing else. Not the dose. Not the timing. Not whether the patient can consent.

The bigger problem is that an odor-triggered workflow fails silently. Vape pens and edibles produce no smell (Section 5), so a patient can arrive with a climbing dose and never trip the trigger at all. The screen needs entry points that do not depend on a nose.

Any of these 3 starts the screen:

- **Odor.** The most common trigger, and the least informative. Section 4 covers handling the smell itself, which is largely a privacy and ventilation problem.
- **Disclosure.** The patient reports use on the health questionnaire or at check-in. This is the trigger you want, and Section 3 is built to produce it.
- **An unexplained finding.** Resting tachycardia in a well patient, red eyes, or a patient who seems off. Any of these justifies running the screen with no odor and no disclosure.

The 3 elements that carry weight, in order

Once the screen is running, 3 findings do the work. They are listed by what each is actually worth at the chair.

1. Vital signs

Heart rate and blood pressure are the only part of this screen with a clinical reason to exist even if cannabis had never come up. THC drives a dose-dependent tachycardia, and the numbers are objective, repeatable, and already in your workflow.

In 302 cannabis-only drug recognition cases, median pulse was 91 bpm against 71 bpm in the 302 controls [7]. Take vitals on any patient who discloses recent use, on any patient you suspect, and always before sedation. Section 7 covers the cardiac window and the thresholds.

2. The eye exam: 4 findings doing different jobs

- **Conjunctival injection.** Bilateral, diffuse, appearing within 5 to 15 minutes of inhaling. In the roadside data it was present in 77.5% of cannabis cases and 3.1% of controls [7], which reads as highly specific until you remember who those controls were. Allergic conjunctivitis, dry eye, contact lenses, a hard cry, a bad night of sleep, and alcohol all produce the same picture, and none of those people were in the control group. Read it as a reason to look further.
- **Lack of convergence.** Hold a pen tip at arm's length and bring it slowly toward the bridge of the patient's nose. Normally both eyes track inward and cross, holding the target to roughly 2 inches. The finding is positive when one or both eyes break outward before that point, at which stage the patient sees 2 tips instead of 1. Score it by watching the eyes rather than by asking the patient. It takes 10 seconds and no equipment. The roadside data show 78.8% of cannabis cases against 10.9% of controls [7]. The placebo-controlled trial is more sobering: 68.6% of the THC group failed convergence, and so did 49.2% of the placebo group [11]. It discriminates, and it does so far less cleanly than the roadside numbers suggest. Convergence insufficiency is also a real condition in its own right and gets more common with age.
- **Rebound dilation.** The one high-specificity finding in the whole screen, and it needs nothing but a penlight. Shine direct light on the eye and watch for 15 seconds. Normally the pupil constricts and stays constricted for as long as the light is on. The finding is positive when it constricts briefly in the first few seconds, then steadily re-opens and never returns to its constricted size. Present is the abnormal result. It was present in 70.9% of cannabis cases against 1.0% of controls, and of the 7 drug categories in the roadside protocol, cannabis is the one that most often produces it [7].

Pair it with convergence. Either finding positive, convergence or rebound dilation, gave 92.7% sensitivity, better than either one alone [7]. Two eye tests, about 25 seconds, no equipment beyond a penlight.

The mistake to avoid is calling normal pupillary unrest a rebound. Unrest is a continuous, irregular flicker in pupil size under steady light, and it is normal. Rebound dilation is a one-way drift that opens and stays open. Unrest wanders both ways. Note also that this finding rests on the roadside data alone: the placebo-controlled trial measured pupil diameter and found no difference between THC and placebo [11], but it never tested rebound dilation. Opioids, anticholinergics, sympathomimetics, and a recent dilated eye exam all move the pupil on their own.

- **Nystagmus, horizontal and vertical.** Cannabis does not produce nystagmus. Vertical gaze nystagmus was found in 0 of 302 cannabis cases and 0 of 302 controls. Horizontal gaze nystagmus appeared in 2.65% of cases against 0.33% of controls, a difference that did not reach significance [7]. Nystagmus belongs to alcohol, CNS depressants, dissociative anesthetics, and inhalants [8], and to anticonvulsants such as phenytoin and carbamazepine, to lithium toxicity, and to vestibular and cerebellar disease.

Which is exactly why it earns a place in a dental screen. You are about to give this patient nitrous, a benzodiazepine, or an opioid, and additive central nervous system depression is the hazard that actually

hurts people (Section 9). Nystagmus in a patient who smells of cannabis tells you something else is on board. Treat it as a hold on any sedation case until you know what.

Do not eyeball 45 degrees

Physiologic gaze-evoked nystagmus is common in healthy people. One study found it in 21% of normal-vision subjects at 10 degrees of gaze and 34% at 20 degrees [9]. Another found it in 71% at 30 degrees, rising to 100% at wider angles [10]. Held at extreme gaze, essentially everyone has it.

So the finding carries weight only when it appears at a modest gaze angle, is sustained, and has no other explanation. Judged by eye at the chair, without training and without a way to measure the angle, this test will generate false positives faster than information. If you are not confident in the finding, treat it as absent and rely on the rest of the screen.

3. Divided attention

Two tasks at once is where cannabis shows itself, because the drug taxes working memory harder than it taxes muscle.

- **Finger to nose.** Eyes closed, head tipped back, arms out, index fingers extended. Call the hand; the patient touches the tip of the index finger to the tip of the nose and returns. 6 trials. Record the misses and which part of the finger landed. In the drug recognition data, 3 or more misses out of 6 performed at 87.1% or better on every diagnostic measure [7].
- **The 2-part question.** Give one instruction with 2 components and see whether both survive. "Take your glasses off and tell me the last thing you ate today." A patient who does one and drops the other has shown you a divided-attention deficit in real time.
- **The version that belongs in the chart.** Use the treatment itself as the second part. "Tell me back in your own words what we are doing today, and name one thing that could go wrong." A patient who can do that has demonstrated understanding and appreciation on the record. A patient who cannot has a documented capacity problem, and you never had to use the word impaired.

Roughly half of sober people fail this battery

The impressive numbers above come from a police population and they do not transfer cleanly to an operatory. In the drug recognition study, the 302 cases were people already arrested on suspicion of impaired driving, and the 302 controls were police officers and academy students: sober, young, fit, and already trained on the very tests being scored [7]. That design inflates every specificity figure in the paper.

A randomized, placebo-controlled trial supplies the correction. Certified drug recognition instructors, the highest training level there is, evaluated 184 cannabis users. Officers classified 81.0% of the THC group as impaired and 49.2% of the placebo group, and believed THC was responsible in 99.2% of everyone they flagged. Eyelid tremor on finger to nose appeared in 75.2% of the THC arm and 71.4% of placebo. On the modified Romberg it was 79.3% and 79.4% [11].

Our patients are older, more anxious, and more medicated than a research volunteer, so our false-positive rate will be worse than 49%. Use this screen to decide how carefully to proceed and whether consent holds. Do not use it to conclude that a patient is high.

And there is a hard age limit on all of it. The 2016 study excluded everyone aged 60 and over, from both the cases and the controls, citing age limitations documented in the original field sobriety test validation work. None of these figures have been shown to hold in a patient over 60, which in a general practice is a

large share of the schedule. Weight the screen accordingly in an older patient and say so in the chart.

Putting it together

There is no score and no cutoff. Findings converge or they do not, and the weight of them drives the decision.

- **One positive finding raises vigilance.** Recheck vitals, slow the visit down, and reassess consent before anything irreversible.
- **Several converging findings with a failed teach-back is a capacity problem.** Elective care waits, and the chart says why.
- **A clean screen in a patient who disclosed use is a reason to proceed with ordinary caution,** documented as such. Disclosure is not a finding against the patient.
- **Nystagmus changes the question from cannabis to what else.** Hold any sedation case until you have the answer.
- **Chart the findings.** Do not chart the conclusion.

Baseline is doing most of the work here

Every element has an innocent explanation. Red eyes come from allergies. Poor convergence comes from age. A miss on finger to nose comes from essential tremor, neuropathy, an old stroke, or plain fear of the dentist. Nystagmus comes from an anticonvulsant at the top of its range. A fast pulse comes from the appointment itself.

When you know the patient's baseline, read against it. When you do not, weight the findings accordingly and say so in the chart. A finding you cannot interpret is worth recording and nothing more.

Edibles climb after they arrive

An edible produces little or no odor and peaks late. A patient can look fine at check-in and slide deeper 30 to 60 minutes into a procedure as the dose keeps rising. Keep reassessing through the visit, since the peak can arrive well after check-in. If a patient is getting more sedated as you work, stop and reassess consent and airway.

7. Vital signs, including heart rate

Check vital signs on any patient who has used cannabis recently or whom you suspect has, and always before sedation. Heart rate and blood pressure are the objective data that turn a hunch into a decision you can defend.

The cardiac window

THC drives a dose-dependent tachycardia and raises myocardial oxygen demand. The risk of a heart attack spikes in roughly the first hour after use, when a patient who used before a stressful procedure stacks sympathetic drive on top of drug-driven tachycardia. Recent data are sobering: a 2025 analysis presented at the American College of Cardiology found cannabis users under 50 with no traditional risk factors were over six times as likely to have a heart attack as non-users. This is showing up in young, otherwise-healthy patients, the exact people you would never flag on a routine history.

Thresholds and actions

No single blood-pressure number fits every patient, so treat these as guidelines and individualize to the person in the chair. A reading has to be read against that patient's own baseline, not a fixed cutoff. The protocol below is a starting point for your office to adapt with clinical judgment.

- **Elevated heart rate with recent use:** treat as the cardiac window. Defer elective treatment, let the patient rest, and recheck rather than push through.
- **Defer guideline, otherwise-normotensive patient:** in a patient with no history of hypertension, a reading around 180 or above over 100 or above after recent cannabis use is a reasonable point to defer elective care, let them rest, and recheck. It is a guideline, not a bright line. A patient with chronic hypertension, or one whose baseline you do not know, needs judgment rather than a number.
- **Hypertensive emergency:** BP at or above 180/120 with symptoms (chest pain, shortness of breath, neurologic changes) is a call to emergency care or a referral, not a dental procedure. This is the medical emergency line and stands on its own, apart from the cannabis question.
- **Denial does not change the number.** If a patient denies use but the vitals and odor say otherwise, act on what you measured. Chart the denial as the patient's words next to your objective findings. It is not worth an argument.

Record the actual numbers, the patient's baseline if known, the time relative to reported use, and the decision you made because of them. Individualize; the numbers here are a floor for discussion, not a substitute for judgment.

8. The cardholder: a clinical flag, not a license to be impaired

A medical card earns the patient a clinical flag and nothing more. It does not entitle the patient to be treated while impaired, and it does not, on its own, justify refusing care.

A patient lawfully certified to use cannabis is, in principle, much like a patient a physician placed on a daytime benzodiazepine for anxiety. Both are using a legally obtained, centrally acting drug under medical authorization. If this office would treat the benzodiazepine patient, then refusing the cannabis patient purely because they hold a card can look like discrimination and can carry real legal exposure.

Before you refuse a cardholder, confer with counsel

Do not write a blanket "no cannabis patients" rule and do not refuse a lawful cardholder on the card alone. This area is unsettled and state-specific. Know your own state's program, remember an out-of-state card is a real possibility, and talk to your attorney before you act, not after you have been served.

9. Clinical decision: proceed, defer, or refer

Once you have separated use from impairment and checked vitals, the decision usually lands in one of three places.

- **Proceed** when the patient is lucid, oriented, able to consent, vitals are acceptable, and the planned care is routine. Document the use, your mental-status read, and the vitals.
- **Defer and reschedule** elective treatment when the patient is impaired, cannot give valid consent, or vitals fall in the cardiac window. Reschedule beyond the acute window: the ADA suggests postponing non-emergency care at least 24 hours, and some guidance advises the patient avoid cannabis for up to a

week before the next visit ^{[3][5]}. Counsel the patient to come to the rebooked visit without having used, and document why you deferred.

- **Refer or call emergency care** for a hypertensive emergency or any acute cardiac or neurologic warning sign.

For a genuine emergency (real pain, swelling, infection) in a patient who is impaired: narrow care to what is truly emergent and does not hinge on consent for a big irreversible procedure. A focused exam, imaging, and temporary or palliative measures stabilize the patient and buy time. Defer definitive work until the patient can consent.

Two cautions when you do treat

- **Epinephrine:** in a patient already tachycardic from recent THC, the cardiovascular stimulation adds up. You can still use epi. Dose it deliberately, aspirate, and watch the patient who is already running hot.
- **Additive CNS depression:** cannabis plus nitrous, a benzodiazepine, or an opioid is additive sedation and respiratory depression. The patient who vaped in the lot is not starting from baseline. Expect sedation doses to behave unpredictably in a chronic user, and consider deferring sedation cases. If the patient is on buprenorphine, remember an opioid on top will mostly not work; manage pain multimodally.

10. Closed-loop communication

The most dangerous failure in the whole workflow is silent: a staff member smells cannabis and does not tell the dentist until after sedation has started. We close that loop by rule.

The rule

- Anyone who notices a cannabis odor, or any sign of recent use, reports it to the treating dentist **before treatment begins, and before any sedation or induction, every time.**
- The dentist confirms the report was received and acknowledged. That acknowledgment is the closed loop. No assumption that “someone must have mentioned it.”
- The dentist asks every patient about cannabis use directly, so the finding never rides on staff observation alone.
- This is a training standard, not a one-time memo. New team members learn it during onboarding.

11. Documentation standard

Good charting is what protects the patient and the office after the fact. For any cannabis-related encounter, record:

- **The objective findings from the screen (Section 6):** odor if present, vital signs with actual numbers and the time taken, the eye exam (conjunctival injection, convergence, rebound dilation, and whether nystagmus was present or absent), divided-attention results including the number of finger-to-nose misses, and the patient’s teach-back in their own words.
- **Record the negatives too.** “No nystagmus, no rebound dilation, converges to 2 inches, 0 of 6 finger-to-nose misses” is a stronger chart entry than silence, and it is what makes a decision to proceed defensible later.
- The patient’s own statements in their words (including any denial), kept separate from your clinical read.
- Whether the patient reported a medical card and the issuing state.

- The decision you made (proceed, defer, refer) and the clinical reason for it.
- For deferrals, the plan and the follow-up you arranged.

Chart the behavior and the decision. Do not chart a conclusion (“patient was high”) you are not equipped to prove.

12. Staff and employee cannabis use

The professional duty is clear: no one on this team treats patients while impaired. Under the ADA Code of Ethics and the principle of non-maleficence, if a colleague or staff member is impaired, we act to limit harm to patients and to urge that person toward help.

What we can do about employee cannabis use beyond that, drug testing, a zero-tolerance policy, discipline for off-hours medical use, screening applicants, or restricting a cardholder from safety-sensitive duties, is **state-dependent and runs straight into employment law**. It is not a decision for the operator.

Our approach:

- **Keep it about observed impairment and fitness for safety-sensitive duties.** You cannot act on the existence of a card alone.
- Document behavior and objective observations, never assumptions.
- **Follow the written personnel policy and involve counsel before any employment action.** Whether you can ask about a card, test, or discipline varies by state, so confer with your attorney first.

Confer with counsel

Before you test, discipline, reassign, or refuse to hire over cannabis, talk to an employment attorney licensed in your state. This section is a framework, not legal advice.

13. Chairside decision algorithm

Use this the moment a patient discloses cannabis use, or when odor or behavior raises the question. A one-page visual version accompanies this policy for posting in the operator.

Odor starts this, but it is not the only way in. Vape pens and edibles are odorless (Section 5), so disclosure on the health history and an unexplained finding (resting tachycardia, red eyes, a patient who seems off) each start the screen on their own. There is no chairside test for cannabis impairment, and this screen is not one. It tells you how carefully to proceed and whether consent holds.

Step 1 • Trigger. Patient discloses use, or staff notes odor or signs of recent use. Any team member reports it to the dentist before treatment (closed loop).

Step 2 • Protect privacy. Move the patient to an operator. No cannabis conversation at the front desk or in the waiting room.

Step 3 • Take the history. “We ask everyone. Have you used cannabis today, when, and how?” Note edibles (they peak late) and any medical card and issuing state.

Step 4 • Check vitals. Record heart rate and blood pressure. Sedation case? Vitals are mandatory.

Step 5 • Run the screen (Section 6). Eyes: injection, convergence to 2 inches, rebound dilation (penlight, 15 seconds), nystagmus present or absent. Divided attention: 6 finger-to-nose trials, then a teach-back of the plan and one risk in the patient’s own words. Nystagmus means something other than cannabis is on board; hold sedation until you know what. Reassess through the visit if an edible may still be climbing.

Step 6 • Decide.

- **Lucid, consents, vitals acceptable, routine care → PROCEED.** Mind epinephrine and additive sedation. Document.
- **Impaired, cannot consent, or vitals in the cardiac window → DEFER** elective care; reschedule; document. Emergency? Limit to what does not need consent for an irreversible procedure. BP guide: around 180+/100+ in an otherwise normotensive patient is a reasonable point to defer; individualize to baseline.
- **BP ≥ 180/120 with symptoms, or acute cardiac / neurologic signs → REFER / call emergency care.**

Throughout • Document. Objective findings and vitals, the patient’s words, the decision, and the reason. Separate what you observed from any conclusion.

Adoption

This policy takes effect on the date above and applies to all clinical and administrative staff. Review it at least annually and whenever your state’s cannabis or employment law changes. Have your own attorney review the finished policy before adoption.

Adopted by (print name): _____

Signature: _____ Date: _____

Practice / title: _____

Sources and references

The policy positions above draw on the following. Cannabis law and clinical evidence change, so verify these against the current versions before you rely on them. Additional clinical sources (cardiac risk, periodontal disease, edible kinetics) are cited in the CE Dojo course "Cannabis & Dentistry."

On Section 6 specifically: the screening evidence comes from roadside drug recognition research and was never validated in a dental population. Sources [7] and [11] disagree about how well these findings actually perform, and [11] has the stronger design. Both are cited so you can see the disagreement instead of inheriting one side of it.

- [1] American Dental Association. "ADA encourages development of best practices for managing patients under influence of marijuana." ADA News, December 2021. adanews.ada.org
- [2] American Dental Association. "Half of Dentists Say Patients Are High at Dental Appointments" (2022 ADA survey; 52% arriving high, 56% limited treatment, 46% increased anesthesia; later trend report, 46% seeing more). ada.org
- [3] American Dental Association. "Patients Using Cannabis: A Dentist's Guide" (capacity assessment, signs of intoxication, epinephrine caution, postpone non-emergency care at least 24 hours). ada.org
- [4] American Dental Association. "Cannabis: Oral Health Effects" (periodontal complications, xerostomia, leukoplakia). ada.org
- [5] Decisions in Dentistry. "Dental Management Considerations for Cannabis Users" and related articles (written practice policy; advise abstaining before an appointment). decisionsindentistry.com
- [6] Appelbaum PS. "Assessment of Patients' Competence to Consent to Treatment." *New England Journal of Medicine*. 2007;357(18):1834-1840. The 4-abilities standard: understanding, appreciation, reasoning, and communicating a choice.
- [7] Hartman RL, Richman JE, Hayes CE, Huestis MA. "Drug Recognition Expert (DRE) examination characteristics of cannabis impairment." *Accident Analysis and Prevention*. 2016;92:219-229. 302 cannabis-only cases against 302 controls. Source of the pulse, lack-of-convergence, rebound dilation, nystagmus, and finger-to-nose figures. The control group was police officers and academy students, which inflates every specificity value in the paper. The study also excluded everyone aged 60 and over from both arms, so none of its figures are established for older patients.
- [8] Couper FJ, Logan BK. "Drugs and Human Performance Fact Sheets." National Highway Traffic Safety Administration, DOT HS 809 725. Maps nystagmus to alcohol, CNS depressants, dissociative anesthetics, and inhalants, and away from cannabis.
- [9] Whyte CA, Petrock AM, Rosenberg M. "Occurrence of physiologic gaze-evoked nystagmus at small angles of gaze." *Investigative Ophthalmology and Visual Science*. 2010;51(5):2476-2478. Physiologic nystagmus in 21% of normal-vision subjects at 10 degrees of gaze and 34% at 20 degrees.
- [10] Ritter MS, Bertolini G, Straumann D, Bögli SY. "Prevalence and Characteristics of Physiological Gaze-Evoked and Rebound Nystagmus: Implications for Testing Their Pathological Counterparts." *Frontiers in Neurology*. 2020;11:547015. Gaze-evoked nystagmus in 71% of healthy subjects at 30 degrees of gaze, rising to 100% at wider angles.
- [11] Marcotte TD, Umlauf A, Grelotti DJ, et al. "Evaluation of Field Sobriety Tests for Identifying Drivers Under the Influence of Cannabis: A Randomized Clinical Trial." *JAMA Psychiatry*. 2023;80(9):914-923. 184 participants. Certified DRE instructors classified 81.0% of the THC group and 49.2% of the placebo group as impaired.

Related frameworks worth reviewing: FSMB Model Guidelines for the Recommendation of Marijuana in Patient Care; "Considerations for Hospital Policies Regarding Medical Cannabis Use" (PMC); and, on the ethics of treating patients under the influence, the Medical Association of the State of Alabama guidance. These address authorization and inpatient use more than the chairside case, so treat them as reference points.

Clinical framework drawn from the CE Dojo course "Cannabis & Dentistry," presented by David Lambert, DDS (oral & maxillofacial surgeon and pharmacist). This template is a starting framework; your state law and your own counsel have the final word.