

Today's Date: _____

RETURNING CAREGIVER INFORMATION

D.O.H. Caregiver Name: _____ Jr. Sr.
First *Middle* *Last*

Patient Name: _____ Jr. Sr.
First *Middle* *Last*

Patient Date of Birth: ___ / ___ / ___ Age: _____

Primary Phone: (_____) _____ - _____ Home Mobile Work Email: _____

Please ✓ the PRIMARY qualifying condition for Medical Marijuana below:

<input type="checkbox"/> Amyotrophic Lateral Sclerosis (ALS)	<input type="checkbox"/> Intractable Seizures
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Multiple Sclerosis (MS)
<input type="checkbox"/> Autism	<input type="checkbox"/> Neurodegenerative Disease
<input type="checkbox"/> Cancer	<input type="checkbox"/> Neuropathies
(if Cancer, what type) _____	<input type="checkbox"/> Opioid Use Disorder
<input type="checkbox"/> Crohn's Disease	<input type="checkbox"/> Parkinson's Disease
<input type="checkbox"/> Dyskinetic and Spastic Movement Disorders	<input type="checkbox"/> Post-Traumatic Stress Disorder (PTSD)
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Severe Chronic Pain
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Sickle Cell Anemia
<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Spinal Cord Injury/Spasticity
<input type="checkbox"/> Huntington's Disease	<input type="checkbox"/> Terminal Illness
<input type="checkbox"/> Inflammatory Bowel Disease (IBD)	<input type="checkbox"/> Tourette Syndrome

Please provide other medical conditions not listed: _____

Please provide a list of any medications (over-the-counter and prescription) that the patient is **CURRENTLY** taking:

Please ✓ the form(s) of Medical Marijuana that your patient prefers (please specify preferred products):

- Dry Leaf _____
- Cartridges / Pods _____
- Disposable Pens _____
- Concentrates _____
- Capsules _____
- Tinctures _____
- Topicals (*patches, lotion*) _____

At which location did you and your patient have your initial Pharmacist consultation (circle): Squirrel Hill / Cranberry / Washington