SOLEVO WELLNESS

Today's Date: _____

RETURNING PEDIATRIC PATIENT INFORMATION

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

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

Patient Date of Birth: ____ / ____ / ____ **Age:** _____ **Gender:** ☐ Male ☐ Female

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

Please ✓ the PRIMARY qualifying condition for Medical Marijuana below:

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

Please provide other medical <u>conditions</u> not listed: _____

_____

Please provide a list of any medications (over-the-counter and prescription) that the patient is <u>CURRENTLY</u> 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 <u>initial</u> Pharmacist consultation (circle): Squirrel Hill / Cranberry / Washington