THE APOTHECARIUM DISPENSARY

New Patient Intake Form

FOR OFFICE USE ONLY: Consult/No Consult □ Form Reviewed by RPh ____ □ Patient Data Entered ___
□ 420 Plymouth Road, Plymouth Meeting □ 2405 Covered Bridge Drive, Lancaster
□ 2701 Lincoln Highway E, Thorndale

DEMOGRAPHIC INFORMATION

Today's Date: _____

Patient Name: _____ Date of Birth: _____/_____/_____
(First) (Last) (MM) (DD) (YYYYY)

Address: _____ Phone Number: _____
(Street)

_____ Email: _____
(City) (State) (Zip)

IF APPLICABLE
PA Department of Health Certified Caregiver Name: _____

Caregiver Relationship to Patient: _____ Caregiver Phone: _____

How did you hear about Apothecarium dispensary? □ Friend/Family □ DOH website

□ Web Search □ Google □ Yahoo □ Facebook □ Newspaper
□ Leafly/Weedmaps □ Apothecarium website □ Physician

□ Another dispensary (which one) _____

□ Event (which event) _____ □ Other (specify) _____

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MEDICAL HISTORY	
I have the following approved medical condition(s) for medical marijuana in Pennsylvania:	
□ Amyotrophic Lateral Sclerosis (ALS)	□ Intractable Seizures
□ Anxiety Disorder	□ Multiple Sclerosis (MS)
□ Autism	□ Neurodegenerative Diseases
□ Cancer, including remission	□ Neuropathies
□ Crohn's Disease	□ Opioid Use Disorder for which conventional therapeutic interventions are contraindicated or ineffective, or for which adjunctive therapy is indicated in combination with primary therapeutic interventions
□ Damage to the nervous tissue of the central nervous system (brain-spinal cord) with objective neurological indication of intractable spasticity, and other associated neuropathies	□ Pain – Severe chronic or intractable pain of neuropathic origin or severe chronic or intractable pain
□ Dyskinetic & spastic movement disorder	□ Parkinson's Disease
□ Epilepsy	□ Post-Traumatic Stress Disorder (PTSD)
□ Glaucoma	□ Sickle Cell Anemia
□ HIV/AIDS	□ Terminal Illness
□ Huntington's Disease	□ Tourette's Syndrome
□ Inflammatory Bowel Disease	

Please list any other medical conditions you are currently under treatment for and/or past surgical procedures:

_____

_____

FEMALES ONLY: Are you pregnant or trying to become pregnant or breastfeeding? □ Yes □ No

Any allergies (medications and/or food)? □ Yes □ No
If "YES", please provide information: _____

Please list any prescription medications you are currently taking, including over the counter (OTC), vitamins, and supplements:

MEDICATION NAME	STRENGTH	HOW OFTEN	REASON FOR TAKING

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Date of Initial Consult: _____

30-day DOH Limit: _____ grams/30 days

30-day limit set initially set by Apothecarium?

□ YES □ NO

Name of Medical Professional for Initial Intake:

_____

Signature of Medical Professional Employee:

_____

Any restrictions set by certifying physician? □ YES □ NO
If "YES", please list: _____

Comments: _____

MARIJUANA CERTIFICATION

Medical Marijuana Card Issue Date: _____/_____/_____ Expiration Date: _____/_____/_____
(MM) (DD) (YYYY) (MM) (DD) (YYYY)

Name and Specialty of Approved Certifying Physician: _____

Facility Location: _____
(Street) (City)

Certifying Physician's Email: _____

Certifying Physician's Phone: _____

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Please INITIAL next to each statement then sign and date the bottom of this form.

_____I understand that I can only purchase medical marijuana product with a valid Pennsylvania Medical Marijuana Card and valid certification in place.

_____I understand, acknowledge, and confirm that the cannabis plant is not regulated by the Food and Drug Administration and is listed as a Schedule I Controlled substance with the U.S. Drug Enforcement Agency. I understand, acknowledge and affirm that it is unlawful for anyone other than a patient/caregiver with a valid medical marijuana card to possess or use medical marijuana products. I understand and acknowledge that it is illegal to divert, transfer, sell, or give any medical marijuana product purchased to anyone other than the patient/caregiver to whom it was dispensed.

_____I understand, acknowledge, and affirm that it is unlawful for any person under the age of 18 to obtain or use medical marijuana products unless they are a patient. I agree to keep all medical marijuana products out of reach of children, other than when a caregiver is administering to a patient.

_____I understand that medical marijuana contains psychoactive ingredients that may affect my coordination, motor skills, and cognition in ways that could impair my ability to drive, operate heavy machinery, or engage in potentially hazardous activity. I understand that there are side effects associated with using medical marijuana and have discussed the risks of medical marijuana with my approved certifying physician.

_____I agree not to open or use purchased medical marijuana products within 1000 feet of Apothecarium dispensary facility or any other place as prohibited by law. I understand it is recommended to use my medical marijuana product within the privacy of my own home.

_____I consent to receive email communications from The Apothecarium Dispensary. I understand I can opt-out of dispensary communications by clicking "unsubscribe" on any individual email.

_____ _____

SIGNATURE OF PATIENT OR CAREGIVER DATE

☐ I have been given a copy of this form.