# PA OPTIONS FOR WELLNESS, INC. / VYTAL Options

**PATIENT NAME** ______________________________ Date: _____ /_____/______

Patient Date of Birth _______/_______/_____________

**PA Dept of Health CAREGIVER (if applicable)** ____________________________

Caregiver Date of Birth _____/_____/______

Are you (the patient) a military veteran? (DD214 form, driver's license flag logo, or military ID): ◯ Yes ◯ No
Are you (the patient) 55 years or older? ◯ Yes ◯ No
Are you (the patient) a first responder? (Fire, EMT, Police) ◯ Yes ◯ No
May we contact you (the patient) by phone/text/email? ◯ Yes ◯ No

Patient Phone: ______________________ Patient Email Address: ___________________________________

**MEDICAL – Your Qualifying Medical Condition(s):**

- ◯ Amyotrophic Lateral Sclerosis
- ◯ Anxiety disorders
- ◯ Autism
- ◯ Cancer, including remission therapy
- ◯ Crohn's disease
- ◯ Damage to the central nervous system (brain-spinal cord) with spasticity or associated neuropathies
- ◯ Dyskinetic and spastic movement disorders
- ◯ Epilepsy
- ◯ Glaucoma
- ◯ HIV / AIDS
- ◯ Huntington's disease
- ◯ Inflammatory Bowel Disease
- ◯ Intractable seizures
- ◯ Multiple Sclerosis
- ◯ Neurodegenerative diseases
- ◯ Neuropathies
- ◯ Opioid use disorder
- ◯ Parkinson's disease
- ◯ Post-traumatic stress disorder
- ◯ Severe chronic or intractable pain of neuropathic origin or severe chronic or intractable pain
- ◯ Sickle cell anemia
- ◯ Terminal illness
- ◯ Tourette syndrome

**List all other health conditions:**

____________________________________________________________________________________

____________________________________________________________________________________

**CANNABIS**

Have you previously used cannabis? ◯ Current user ◯ Used previously ◯ Never used

Frequency of cannabis use: ________________________________________________________________

Have you previously visited another dispensary? ◯ Yes ◯ No

Would you like a consultation with our pharmacist? ◯ Yes ◯ No

**PLEASE TURN OVER TO PAGE 2**

## MEDICATION

Current medication (prescription/over-the-counter/herbal supplements):

| 1. | 6. |
|---|---|
| 2. | 7. |
| 3. | 8. |
| 4. | 9. |
| 5. | 10. |

Allergies (medication/food/other):

_____________________________________________________________________________

## RESEARCH

Would you like to be contacted to participate in future medical cannabis research and studies?

◯ Yes ◯ No

## HOW DID YOU HEAR ABOUT US? (Circle one.)

**Social Media** **Billboard** **Friend/Family** **Event** **Other: ____________________**

## ACKNOWLEDGEMENT

Please sign the bottom of this page with your understanding, acknowledgement, and confirmation of the following below:

1. Only Pennsylvania patients and caregivers may purchase medical marijuana from a licensed PA dispensary with a valid certification from a licensed physician within the Act 16 program.
2. Cannabis is not regulated by the Food and Drug Administration and is classified as a Schedule I controlled substance with the U.S. Drug Enforcement Agency.
3. It is unlawful for any patient/caregiver to sell, share, divert their products to any other individual, including minors under 18.
4. The medical marijuana must remain in the commonwealth of Pennsylvania and cannot cross state lines.
5. Medical marijuana contains psychoactive ingredients that may affect coordination, motor skills, cognition. It should not be used before/during operation of a vehicle or heavy machinery.
6. The side effects have been discussed by either the certifying physician and/or the medical professional (pharmacists) on-site at the dispensary.
7. It is unlawful to smoke/combust any medicated products within the Act 16 program.
8. You must keep the products in the original containers in which the products were dispensed.
9. Products must leave the dispensary sealed and intact.

**Signature of Patient or Caregiver** ______________________________________

**Date** ______________________________________