420 Plymouth Rd
Plymouth Meeting, PA 19462
(484) 531-4420
www.ilerahealthcare.com

New Patient Intake Form

DEMOGRAPHIC INFORMATION

Today's Date: _____

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

Address: _____ Phone Number:
(Street)

(_____) _____-_____

Permission to leave voicemail?
☐ YES ☐ NO

_____

(City) (State) (Zip)

Email:
_____

PA Department of Health Certified Caregiver Name (if applicable): Caregiver Phone:

_____ (_____)_____-_____

Caregiver Relationship to Patient: _____

Permission to discuss information with family or other caregivers?
☐ YES ☐ NO
If yes, please provide name and contact information: _____

How did you hear about Ilera Healthcare?
☐ Friend/Family ☐ Web Search ☐ Physician ☐ Event ☐ Social Media
☐ Leafly / Weedmaps

MARIJUANA CERTIFICATION

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

Name and Specialty of Approved Certifying Physician: _____

Certifying Physician's
Phone:(_____)_____ Facility Location: _____

Permission to discuss information with certifying physician?
☐ YES ☐ NO

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

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

_____

_____

Are you pregnant, trying to become pregnant or breastfeeding? Yes_____ No_____

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

MEDICATION NAME	STRENGTH	HOW OFTEN	REASON FOR TAKING

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SOCIAL HISTORY

Have you used marijuana in the past?	☐ YES	☐ NO
Are you currently using marijuana?	☐ YES	☐ NO
If "YES", how often? _____ per month	_____ per week	_____ per day
Do you use any form of nicotine?	☐ YES	☐ NO
If "YES", what form and how often?	Nicotine type: _____	Nicotine Usage: _____ per _____
Do you drink alcohol?	☐ YES	☐ NO
If "YES", how often?	Alcohol Usage: _____ drinks per _____	
Do you use any other substance? (ex: opioids not prescribed to you, cocaine, LSD, etc.)	☐ YES	☐ NO
If yes, what form and how often?	Substance type: _____	Substance Usage: _____ per _____

Other Comments: _____

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FOR OFFICE USE ONLY

Date of Initial Consult: _____

30-day DOH limit: _____ g per 30 days

30-day limit set initially set by Ilera HCP?

☐ YES ☐ NO

Name of Dispensary Employee for Initial Intake:
_____

Signature of Dispensary Employee:
_____

Comments:

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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 Ilera Healthcare's 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.

_____ _____

Signature of Patient or Caregiver **Date**
Date

☐ I have been given a copy of this form.