CONFIDENTIAL

Florida Low-THC Treatment Plan - INITIAL

Date of treatment plan submission: ____/____/_____

Patient Information

Registry ID Number: _____ Patient Zip Code: _____

Patient DOB: ____/____/_____ Race/Ethnicity: _____

Provider information

Name: _____ Address: _____

NPI #: _____ DEA#: _____ Medical License#: _____

Facility Name: _____ Phone: _____ Fax: _____

Specialty/Board certifications: _____

Concurring physician if patient < 18 years: _____

Cannabis Order

Date of Order: ___/___/____ Dose: _____ Type of Administration: _____

Planned duration _____

Clinical History and Condition

Indication(s) for cannabis treatment

Chief complaint for evaluation of cannabis treatment:

List of symptoms

	Type/frequency of onset/severity	Symptom upon onset/duration
1. _____		
2. _____		
3. _____		

Prior treatment(s), how long was each treatment attempted, and outcomes of each treatment

Social Hx

EtOH Y/N If Yes, *how often*: _____

Smoking Y/N If Yes, how much per day: _____

Illicit Drugs Y/N If yes, what type(s) and how often: _____

Patient's co-morbidities/disease history (circle all that apply)

weight loss, hepatitis, rheumatic fever, mono, flu, arthritis, Ca, gout, asthma/COPD, pneumonia, thyroid dx, blood dyscrasias, ASCVD, HTN, UTIs, DM, seizures, operations, injuries, PUD/GERD, hospitalizations, psych hx, OTHER: _____

Current Medications

Psychoactive Medications:

Med Name	Dosage	Regimen (e.g., one BID)	Target Symptoms

Other Rx Medications:

Med Name	Dosage	Regimen (e.g., one BID)	Target Symptoms

OTC/Supplements/Herbals/Other Self-Medication:

Med Name	Dosage	Regimen (e.g., one BID)	Target Symptoms

Plan

Goals:

Monitoring Plan of Patient's Symptoms:

Planned follow-up encounter date:

Considering your total clinical experience with this particular population, how ill is the patient at this time?

(Check most appropriate response)

☐ 1=normal, not at all ill ☐ 2=borderline ill ☐ 3=mildly ill

☐ 4=moderately ill ☐ 5=markedly ill ☐ 6=severely ill

☐ 7=among the most extremely ill patients