

# Wyoming Hemp Extract Registry

6101 Yellowstone Rd., Suite 510

Cheyenne, WY 82002

Phone: (307) 777-3744



## PATIENT EVALUATION RECORD

### *For Internal WDH Use Only*

1. This form is to be completed by a board certified neurologist licensed without restrictions to practice in the state of Wyoming.  
(The neurologist may prepare and sign this form or he/she may issue a statement with the required information on the neurologist's letterhead).
2. Sections A, B, & C are *required* for submission. Section D is *optional*. Section E is *required for renewal*.
3. A completed evaluation record form or statement must be submitted to the Department of Health with the application package or within 5 business days of completing the written certification.

<input type="checkbox"/> Initial Application		<input type="checkbox"/> Renewal Application	
<b>Section A: Patient Information</b>			
1. Last Name:		2. First Name:	
		3. Middle Initial:	
4. Date of Birth:		5. Today's Date:	
<b>Section B: Required Patient Medical History</b>			
1. Date of Office/Clinical Visit:		2. Has this patient received a diagnosis of epilepsy?	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Does this patient exhibit symptoms or signs indicative of intractable epilepsy?			
<input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>Section C: Neurologist Information</b>			
1. Last Name:		2. First Name:	
		3. Middle Initial:	
2. DOPL License Number & Expiration Date:			
3. Signature of Neurologist:			

## Section D:

## Optional Patient Medical History

The data and information provided in response to this section will be maintained by the Wyoming Department of Health and may only be used for approved research uses as listed in the Statute.

1. Date of Onset of Epilepsy:

2. Seizure Type(s) and Frequency (per month):

3. Antiepileptic Medication(s):

Dose/Frequency:

Reported Side Effects:

Currently Using?

a.

Yes  No

b.

Yes  No

c.

Yes  No

d.

Yes  No

4. Other Treatments Used: (Please check all that apply)

Vagal Nerve Stimulator

Ketogenic Diet

Other: \_\_\_\_\_

5. Space for additional medications/treatments, if needed:

## Section E:

## Renewal Information

This section is only required for those applying for a renewal.

1. Patient's Response to Hemp Extract: (Effect on seizure control and any adverse side effects)