Case Questionnaire: Multistate Outbreak of Vitamin K-Dependent Antagonist Coagulopathy Associated with Synthetic Cannabinoids Use (version 4/12/2018)

Public health is contacting you because we are looking at a number of people who has developed bleeding problems following use of various synthetic cannabinoid. Would you have a few minutes to review some information with me? We are trying to better understand the illnesses that are being described and what products may be linked to illness.

Case ID ________________

Date of interview ___/___/___  Interviewer ________________________________

Interviewer’s Place of Employment ________________________________

Who is being interviewed (Circle)?  Patient  Other ____________________

CONTACT AND DEMOGRAPHIC INFORMATION

1. Last name __________________
2. First name __________________
3. Street Address _______________
4. City_____________________  County ______________
5. Zip code ___________  Phone # ___________________________
6. Sex (circle)   M   F
7. Race (circle)  African American   White   Asian   Other _______________
8. Ethnicity (circle)  Hispanic   Non-Hispanic
9. Date of Birth ___/___/___  Age (years) __________________
10. Occupation _________________________

SYMPTOMS AND MEDICAL CARE

11. Clinical status at time of interview (ICU, hospitalized, discharged) ___________________________
12. When did you first begin to feel ill? ___/___/___  time _______am/pm
13. Did you have any of the following symptoms (Circle below; DK=Don’t know)
   a. Nose bleed YES/NO/DK
   b. Bleeding gums or mouth YES/NO/DK
   c. Coughing up blood YES/NO/DK
   d. Vomiting blood YES/NO/DK
   e. Blood in your urine YES/NO/DK
   f. Blood in your stool YES/NO/DK
   g. Bleeding from wound/sore/venipuncture site YES/NO/DK
   h. Vaginal bleeding or heavy menstrual bleeding YES/NO/DK
   i. Blood spots on skin YES/NO/DK
   j. Bruising YES/NO/DK
   k. Hematoma(s) YES/NO/DK
   l. Pain on the side or small of your back YES/NO/DK
   m. Other back pain YES/NO/DK
   n. Abdominal pain YES/NO/DK
   o. Other: ________________________________
14. What symptom(s) began first? 1st symptom: __________________ 2nd symptom: __________________

15. Where did you first seek medical care?
   a. What type of facility
      i. Did not seek medical care
      ii. Primary care doctor
      iii. Urgent care facility
      iv. Emergency department
      v. Hospital
   b. Name and location of facility ____________________________________________
   c. What was the diagnosis you received? ____________________________________ (DK)
   d. What treatments did you receive?
      i. Vitamin K
      ii. Frozen fresh plasma (FFP)
      iii. Prothrombin Complex Concentrates (PCC)
      iv. Other __________________________
      v. None
      vi. Don’t know
   e. Were you hospitalized overnight at this facility? YES/NO/NA
   f. Dates of hospitalization ___/___/___ to ___/___/____
   g. Did you complete your treatment? YES/NO/DK
   h. Did you sign out against medical advice (AMA)? YES/NO/DK

16. Did you need to go to a second facility for care?
   a. What type of facility
      i. Did not seek medical care
      ii. Primary care doctor
      iii. Urgent care facility
      iv. Emergency department
      v. Hospital
   b. Name and location of facility ____________________________________________
   c. What was the diagnosis you received? ____________________________________ or DK
   d. What treatments did you receive?
      i. Vitamin K
      ii. Frozen fresh plasma (FFP)
      iii. Prothrombin Complex Concentrates (PCC)
      iv. Other __________________________
      v. None
      vi. Don’t Know
   e. Were you hospitalized overnight at this facility? YES/NO/NA
   f. Dates of hospitalization ___/___/___ to ___/___/____
   g. Did you complete your treatment? YES/NO/DK
   h. Did you sign out against medical advice (AMA)? YES/NO/DK

17. Do you have any medical conditions that make it difficult for your blood to clot? Examples of this include von Willebrand disease, hemophilia, or other clotting factor deficiencies. YES/NO/DK
   a. If yes, please describe: ____________________________________________
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BLOOD OR PLASMA DONATION

18. Did you donate any blood or plasma in the month prior to when you got sick (bleeding)? YES/NO/DK
19. Date interviewed about plasma donation ___/___/___
20. Date donated plasma/blood? ___/___/___ or DK
21. Name of place where donated?___________________ or DK
   a. Address________________________ ________________ or DK

EXPOSURES TO MEDICATIONS, SUPPLEMENTS, AND OTHER SUBSTANCES

In the 3 months before you became ill:

22. Did you take any over-the-counter medications? YES/NO/DK
    If yes, please list: ________________________________
23. Did you take any blood thinners or other anticoagulants? YES/NO/DK
    If yes, please list: ________________________________
24. Are you taking any NSAIDs? YES/NO/DK
    If yes, please list: ________________________________
25. Did you take any OTHER prescription medications not listed above? YES/NO/DK
    If yes, please list: ________________________________
26. Did you take any vitamins, nutritional supplements, or herbal supplements? YES/NO/DK
    If yes, please list type and brand: ________________________________
27. Did you use kratom before you became ill? YES/NO/DK
    If yes, where did you obtain it (circle all that apply)? STORE/ONLINE/FRIEND/DEALER/DK/OTHER: ___________ ________________
   a. How often do you normally use synthetic cannabinoids (K2/spice)?
      i. More than once a day
      ii. Once a day
      iii. Few days a week
      iv. Once a week
      v. Once a month
      vi. Few times a year
   b. Why do you use it? (circle all that apply)
      i. Doesn’t show up in drug tests
      ii. Marijuana is not legal in my state
      iii. To get high
      iv. Medicinal purposes (e.g., pain management, anxiety, depression)
      v. Addiction
      vi. Social use (e.g., at parties or with friends)
      vii. Other: ________________________________
      viii. Don’t know
   c. Date last used? ___/___/___ or DK or other response: ________________________________
   d. How did you use it (circle all that apply)? SMOKE/EAT/VAPE/OTHER: ________________________________
e. Where did you get it from (circle all that apply)? STORE/ONLINE/FRIEND/DEALER/DK/ OTHER: ____________________

f. Location where product was obtained (City/State): ____________________
   i. If ordered online, list website: ____________________

g. What was the name(s) of the product(s) (circle all that apply)?
   AK47   Kush   Mind Trip   Red Giant   Yellow Giant
   Blue Giant   Green Giant   OMG   Scooby Doo   Scooby Snax
   Sexy Monkey   Kisha Cole   Joker   Cloud 9   Bling Bling Monkey
   DK   Other: ____________________
   If DK, provide description of packaging (images, colors, etc.): ____________________

h. Do you have any of it left? YES/NO/DK
i. Did you modify the drugs with rat poison or any other substances? YES/NO/DK
If yes, with what and why? ____________________

j. Did you notice a change (e.g., color, taste, smell, quality) in the synthetic cannabinoid product? YES/NO/DK
   If yes, what type of change? ____________________
   If yes, how long ago did you notice this change? ____________________

28. Did you smoke marijuana in the 3 months before you became ill? YES/NO/DK
   a. If yes, where did you obtain the product (circle all that apply)?
      STORE ONLINE PERSON OTHER: ____________________
   b. Did you or someone else modify or add anything to the marijuana? YES/NO/ DK
      If yes, please describe: ____________________
   c. Do you have any of the marijuana left? YES/NO/DK

29. Did you use any other illicit drugs? YES/NO/DK
   If yes, type: ____________________

30. Did you share or use marijuana or synthetic cannabinoids with anyone else? YES/NO/DK

31. Did anyone else who shared marijuana or synthetic cannabinoids with you develop any illness? YES/NO/DK
   a. If yes, can we have their names and contact information so we can contact them and advise them of this situation?

32. To your knowledge, did you consume anything with rat poison or rodenticide in it?
   a. If yes, date consumed ___/___/___
   b. If yes, explain: ____________________
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TRAVEL

33. Did you spend any time outside of your county/state of residence during the 72 hours before you became ill? YES/NO/DK
   a. If yes, please complete the table below:

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<thead>
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<th>Country</th>
<th>State</th>
<th>City</th>
<th>Dates of Travel</th>
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CONTACTS

34. Do you live with anyone else? YES/NO/DK
   a. If yes, are any of your household members ill with similar symptoms? YES/NO/DK
   b. Please describe: __________________________

35. Do you know of anyone else with similar symptoms? YES/NO/DK
   a. If yes, please provide name and contact information__________

ADDITIONAL COMMENTS

Thank you very much for your time. We appreciate the information you were able to provide.

If you have any questions or additional information to provide you can reach [us or xxx health department] at [insert phone number]