

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: _____

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14. What symptom(s) began first? 1st symptom: _____ 2nd symptom: _____
15. Where did you first seek medical care?
- What type of facility
 - Did not seek medical care
 - Primary care doctor
 - Urgent care facility
 - Emergency department
 - Hospital
 - Name and location of facility _____
 - What was the diagnosis you received? _____ (DK)
 - What treatments did you receive?
 - Vitamin K
 - Frozen fresh plasma (FFP)
 - Prothrombin Complex Concentrates (PCC)
 - Other _____
 - None
 - Don't know
 - Were you hospitalized overnight at this facility? YES/NO/NA
 - Dates of hospitalization ___/___/___ to ___/___/___
 - Did you complete your treatment? YES/NO/DK
 - Did you sign out against medical advice (AMA)? YES/NO/DK
16. Did you need to go to a second facility for care?
- What type of facility
 - Did not seek medical care
 - Primary care doctor
 - Urgent care facility
 - Emergency department
 - Hospital
 - Name and location of facility _____
 - What was the diagnosis you received? _____ or DK
 - What treatments did you receive?
 - Vitamin K
 - Frozen fresh plasma (FFP)
 - Prothrombin Complex Concentrates (PCC)
 - Other _____
 - None
 - Don't Know
 - Were you hospitalized overnight at this facility? YES/NO/NA
 - Dates of hospitalization ___/___/___ to ___/___/___
 - Did you complete your treatment? YES/NO/DK
 - 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
- 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: _____
28. Did you consume or smoke synthetic cannabinoids (for example 'K2', 'spice', 'fake weed', 'legal weed', 'blaze', or 'genie') in the **3 months** before you became ill? YES/NO/DK
- 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: _____

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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:

Country	State	City	Dates of Travel

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]