

MEDICAL RECORDS ABSTRACTION

Type of Records reviewed (mark all that apply):

- Emergency Medical Services (EMS)/Ambulance notes*
- Emergency Department Notes
- Hospital chart**

- Coroner/Medical Examiner Documentation***
- Poison Center Chart
- Other _____

*If patient not brought in or seen by EMS, complete disposition and **skip** to Section B.

If patient was admitted **also complete Section C

***If patient is deceased **also** complete Section D.

- Mode of Presentation to ED:** Self/Ambulatory Friends/Family Ambulance Police Transfer
- Other _____

Presentation & Disposition

Date of presentation (mm/dd/yyyy): _____ Not Recorded

Disposition (Check all that apply) Not recorded

- | | |
|--|---|
| <input type="checkbox"/> Left AMA (Against Medical Advice) | Date: _____ (mm/dd/yyyy) |
| <input type="checkbox"/> Treated and Released | ED discharge date: _____ (mm/dd/yyyy) |
| <input type="checkbox"/> Admitted to observation (OBS) | OBS discharge date: _____ (mm/dd/yyyy) |
| <input type="checkbox"/> Admitted to General Medicine | Hospital discharge date: _____ (mm/dd/yyyy) |
| <input type="checkbox"/> Admitted to ICU | ICU discharge date: _____ (mm/dd/yyyy) |
| <input type="checkbox"/> Deceased | Date of death: _____ (mm/dd/yyyy) |

Discharge Diagnosis: (select all that apply) Not recorded

- | | | |
|---|--|--|
| <input type="checkbox"/> Drug Overdose | <input type="checkbox"/> Altered Mental Status | <input type="checkbox"/> Seizure |
| <input type="checkbox"/> Tachycardia | <input type="checkbox"/> Hyperthermia | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Acute Renal Failure | <input type="checkbox"/> Rhabdomyolysis | <input type="checkbox"/> Respiratory Failure |
| <input type="checkbox"/> Cardiopulmonary Arrest | <input type="checkbox"/> Other: _____ | |

General Information

Chief Complaint (first recorded by MD or other practitioner):

Synthetic cannabinoid use:

- Not recorded Yes

Synthetic cannabinoid use details (product name, quantity, place obtained, etc.)

Name of synthetic cannabinoid product: _____ Not recorded

Time passed since last use: ≤ 24 hours >24-36 hours >36 hours Not recorded

Other details:

Mental Status prior to Medication Administration

(mark all that apply, including those in chief complaint):

Obtained from:

- | | |
|---|---|
| <input type="checkbox"/> Prehospital Records | <input type="checkbox"/> ED Records |
| <input type="checkbox"/> Transfer Records | <input type="checkbox"/> Hospital Records |
| <input type="checkbox"/> Medical Examiner / Coroner | |

- Normal Not recorded
 Agitated Confused Violent/Aggressive Hallucinating Paranoid
 Anxious Somnolent Unresponsive Seizures Psychosis
 Other _____

Past Medical History

- No Past Medical History Yes (if yes, specify below) Not recorded

 High blood pressure
 Heart disease
 Kidney disease
 Liver disease
 Diabetes
 Seizure disorder
 Mental illness
 Substance abuse
 Other _____

Review of Symptoms at Time of Presentation

(mark all that apply):

- Not recorded

 Fatigue Chest Pain Abdominal Pain Sweating
 Nausea/Vomiting Palpitations Dark Urine Confusion
 Headache Shortness of Breath Muscle pain
 Other: _____

Physical Exam Findings/Descriptors at Time of Presentation

(mark all that apply):

- Skin:** Normal Not recorded
 Diaphoretic (sweating) Flushed Other _____
- Mucous Membranes:** Normal Not recorded
 Dry Other _____
- Eyes:** Normal Not recorded
 Pupils dilated Pupils constricted Nystagmus Injected Eyes Other _____
- Cardiovascular:** Normal Not recorded
 Tachycardia Bradycardia Arrhythmia Other _____
- Respiratory:** Normal Not recorded
 Bradypnea Tachypnea Dyspnea Other _____
- Gastrointestinal:** Normal Not recorded Vomiting
 Abnormal bowel sounds Tender Other _____
- Neurologic:** Normal Not recorded Altered Mental Status
 Hyperreflexia Hyporeflexia Tremor Other _____

Initial cardiac rhythm: Not recorded Normal sinus Abnormal, please describe: _____**Imaging Findings at Presentation** Not Recorded Performed*If performed, mark all that apply:* Head CT Normal Abnormal Specific abnormal findings _____ Chest X-ray Normal Abnormal Specific abnormal findings _____ Other(s) Specify _____ Normal Abnormal Specific abnormal findings _____**Prehospital Data** No Prehospital Data Available**Earliest Prehospital Vital Signs** Cardio Pulmonary Arrest Not Recorded

Date: _____ (mm/dd/yyyy)

Temperature _____ ° F C (Temp: Not Recorded) Heart Rate: _____ /minute; Blood Pressure: _____ / _____Respiratory Rate: _____ /minute %O₂ Saturation: _____ % (O₂ sat: Not Recorded)**Prehospital Interventions** Not Recorded Performed*If performed, mark all that apply:* Intubation, specify reason (e.g. hypoventilation, airway protection) _____ Cardiopulmonary resuscitation Defibrillation**Prehospital Medications** Not Recorded Performed*If performed, mark all that apply:* Benzodiazepine Name (s) : _____ Antipsychotics Name (s): _____ Antidotes Name (s): _____**B. ED Data** No ED Data Available**Earliest ED Vital Signs:** Cardio Pulmonary Arrest Not Recorded

Date: _____ (mm/dd/yyyy)

Temperature _____ ° F C Heart Rate: _____ /minute; Blood Pressure: _____ / _____

Respiratory Rate: _____ /minute % Oxygen Saturation: _____ %

ED Interventions

Not Recorded Performed

If performed, mark all that apply:

- Intubation, specify reason (e.g. hypoventilation, airway protection) _____
- Cardiopulmonary resuscitation
- Defibrillation
- Hemodialysis
- Cooling Measures

ED Medications (see instruction sheet for included medications)

Not Recorded Performed

If performed, mark all that apply:

- Benzodiazepine Name (s) : _____
- Antipsychotics Name (s): _____
- Antidotes Name (s): _____
- Vasopressor Name (s): _____

C. Inpatient Data

No Inpatient Data Available

Most abnormal laboratory values during hospitalization

Blood Chemistry: Not Recorded Performed
If abnormal, specify max values during hospitalization

		Lowest Abnormal Value	Highest Abnormal Value
Na	<input type="checkbox"/> Normal	_____	_____
K	<input type="checkbox"/> Normal	_____	_____
HCO ₃	<input type="checkbox"/> Normal	_____	_____
BUN	<input type="checkbox"/> Normal	_____	_____
Creatinine	<input type="checkbox"/> Normal	_____	_____
Glucose	<input type="checkbox"/> Normal	_____	_____
Anion Gap	<input type="checkbox"/> Normal	_____	_____

Liver Panel: Not Recorded Performed
If abnormal, specify max values during hospitalization

		Highest Abnormal Value
AST	<input type="checkbox"/> Normal	_____
ALT	<input type="checkbox"/> Normal	_____
Total Bili	<input type="checkbox"/> Normal	_____
Alk Phos	<input type="checkbox"/> Normal	_____
Other:		
CK/CPK	<input type="checkbox"/> Not Recorded <input type="checkbox"/> Normal	_____
Lactate/Lactic Acid	<input type="checkbox"/> Not Recorded <input type="checkbox"/> Normal	_____
Troponin	<input type="checkbox"/> Not Recorded <input type="checkbox"/> Normal	_____

Inpatient Interventions

Not Recorded Performed

If performed, mark all that apply:

- Intubation, specify reason (e.g. hypoventilation, airway protection) _____
- Cardiopulmonary resuscitation
- Defibrillation
- Hemodialysis
- Cooling Measures

Inpatient Medications

Not Recorded Performed

If performed, mark all that apply:

- Benzodiazepine Name (s) : _____
- Antipsychotics Name (s): _____
- Antidotes Name (s): _____
- Vasopressor Name (s): _____

Other Data/Notes:

D. ME or Coroner Record Review

No Prehospital Data Available

Date and Time of Death (mm/dd/yyyy)/(hh:mm A.M./P.M.):

Check if time of death is estimated

Significant Positive Gross Autopsy Findings:

Significant Positive Histopathology Autopsy Findings:

Blood Chemistry: Not Recorded Performed
If abnormal, specify max values during hospitalization

		Lowest Abnormal Value	Highest Abnormal Value
Na	<input type="checkbox"/> Normal	_____	_____
K	<input type="checkbox"/> Normal	_____	_____
HCO3	<input type="checkbox"/> Normal	_____	_____
BUN	<input type="checkbox"/> Normal	_____	_____
Creatinine	<input type="checkbox"/> Normal	_____	_____
Glucose	<input type="checkbox"/> Normal	_____	_____
Anion Gap	<input type="checkbox"/> Normal	_____	_____

Liver Panel: Not Recorded Performed
 Highest
If abnormal, specify max values during hospitalization

		Highest Abnormal Value
AST	<input type="checkbox"/> Normal	_____
ALT	<input type="checkbox"/> Normal	_____
Total Bili	<input type="checkbox"/> Normal	_____
Alk Phos	<input type="checkbox"/> Normal	_____

Other:

CK/CPK	<input type="checkbox"/> Not Recorded	<input type="checkbox"/> Normal	_____
Lactate/Lactic Acid	<input type="checkbox"/> Not Recorded	<input type="checkbox"/> Normal	_____
Troponin	<input type="checkbox"/> Not Recorded	<input type="checkbox"/> Normal	_____

<p>Drug Screen: <input type="checkbox"/> Not Recorded <input type="checkbox"/> Performed <i>If performed, mark all that apply</i></p> <table style="width: 100%; border: none;"> <tr> <td>Ethanol</td> <td><input type="checkbox"/> Negative</td> <td><input type="checkbox"/> Blood +</td> <td><input type="checkbox"/> Urine +</td> </tr> <tr> <td>Opioids</td> <td><input type="checkbox"/> Negative</td> <td><input type="checkbox"/> Blood +</td> <td><input type="checkbox"/> Urine +</td> </tr> <tr> <td>Benzodiazepines</td> <td><input type="checkbox"/> Negative</td> <td><input type="checkbox"/> Blood +</td> <td><input type="checkbox"/> Urine +</td> </tr> <tr> <td>Cocaine</td> <td><input type="checkbox"/> Negative</td> <td><input type="checkbox"/> Blood +</td> <td><input type="checkbox"/> Urine +</td> </tr> <tr> <td>Barbiturates</td> <td><input type="checkbox"/> Negative</td> <td><input type="checkbox"/> Blood +</td> <td><input type="checkbox"/> Urine +</td> </tr> <tr> <td>Methamphetamines</td> <td><input type="checkbox"/> Negative</td> <td><input type="checkbox"/> Blood +</td> <td><input type="checkbox"/> Urine +</td> </tr> <tr> <td>THC/cannabinoids</td> <td><input type="checkbox"/> Negative</td> <td><input type="checkbox"/> Blood +</td> <td><input type="checkbox"/> Urine +</td> </tr> </table>	Ethanol	<input type="checkbox"/> Negative	<input type="checkbox"/> Blood +	<input type="checkbox"/> Urine +	Opioids	<input type="checkbox"/> Negative	<input type="checkbox"/> Blood +	<input type="checkbox"/> Urine +	Benzodiazepines	<input type="checkbox"/> Negative	<input type="checkbox"/> Blood +	<input type="checkbox"/> Urine +	Cocaine	<input type="checkbox"/> Negative	<input type="checkbox"/> Blood +	<input type="checkbox"/> Urine +	Barbiturates	<input type="checkbox"/> Negative	<input type="checkbox"/> Blood +	<input type="checkbox"/> Urine +	Methamphetamines	<input type="checkbox"/> Negative	<input type="checkbox"/> Blood +	<input type="checkbox"/> Urine +	THC/cannabinoids	<input type="checkbox"/> Negative	<input type="checkbox"/> Blood +	<input type="checkbox"/> Urine +	<p>Other Drug Screen: <input type="checkbox"/> Not Recorded <input type="checkbox"/> Performed <i>If performed, mark all that apply</i></p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Other: _____</td> <td><input type="checkbox"/> Negative</td> <td><input type="checkbox"/> Blood +</td> <td><input type="checkbox"/> Urine +</td> </tr> <tr> <td><input type="checkbox"/> Other: _____</td> <td><input type="checkbox"/> Negative</td> <td><input type="checkbox"/> Blood +</td> <td><input type="checkbox"/> Urine +</td> </tr> <tr> <td><input type="checkbox"/> Other: _____</td> <td><input type="checkbox"/> Negative</td> <td><input type="checkbox"/> Blood +</td> <td><input type="checkbox"/> Urine +</td> </tr> <tr> <td><input type="checkbox"/> Other: _____</td> <td><input type="checkbox"/> Negative</td> <td><input type="checkbox"/> Blood +</td> <td><input type="checkbox"/> Urine +</td> </tr> </table> <p>Synthetic cannabinoid use: <input type="checkbox"/> Not recorded <input type="checkbox"/> Yes</p> <p>Synthetic cannabinoid use details (<i>product name, quantity, place obtained, etc.</i>) Name of synthetic cannabinoid: _____ Other details: _____</p>	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Negative	<input type="checkbox"/> Blood +	<input type="checkbox"/> Urine +	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Negative	<input type="checkbox"/> Blood +	<input type="checkbox"/> Urine +	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Negative	<input type="checkbox"/> Blood +	<input type="checkbox"/> Urine +	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Negative	<input type="checkbox"/> Blood +	<input type="checkbox"/> Urine +
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<p>Other Data/Notes (please include any past medical history or any pertinent case history listed):</p> 																																													
<p>Cause of Death: _____</p>																																													

SPECIFIC MENTAL STATUS DESCRIPTORS:

Normal

AAOx3
Alert and Oriented

Agitated-Delirium

AGITATION or EXCITATION PLUS one of following:
 Delirious
 Delirium
 Confused
 Altered / Altered mental status

Violent

Violent
 Angry
 Agitated (but not delirious)

Hallucinating

Visual hallucinations
 Auditory hallucinations

Paranoid

Paranoid / Paranoia

Anxious

Anxious
 Nervous

Somnolent

Somnolent

Fatigued
 Sedated
 Sleeping
 Depressed mental status
 Difficult to arouse

Unresponsive

Unresponsive
 Comatose / Coma
 GCS-3

Seizures

Seizures
 Seizure-like activity
 Epileptic activity

Psychosis/Psychotic

Psychosis
 Psychotic
 Out of touch with reality

SPECIFIC MEDICATION DESCRIPTORS:

Do not include medications used in CPR/ACLS/code

Benzodiazepines:

Lorazepam (Ativan)
 Diazepam (Valium)
 Midazolam (Versed)
 Alprazolam (Xanax)
 Clonazepam (Klonopin)

Case ID#: _____

Antipsychotics:

Haldoperidol (Haldol)
Chlorpromazine (Thorazine)
Droperidol (Inapsine)
Prochlorperazine (Compazine)
Aripiprazole (Abilify)
Olanzapine (Zyprexa)
Quetiapine (Seroquel)
Ziprazidone (Geodon)
Risperidone (Risperdol)

Antidotes:

Naloxone (Narcan)
Flumazenil (Romazicon)
Physostigmine (Antilirium)
N-acetyl cysteine (Acetadote)
Activated charcoal
Calcium
Dantrolene
Bromocriptine
High-dose insulin

Intralipid

Vasopressors:

Epinephrine (Adrenalin)
Norepinephrine (Levophed)
Vasopressin (Vasostriect)
Dopamine (Intropin)
Dobutamine
Milrinone

SPECIFIC COOLING MEASURES:

Active cooling
Fans / Fans Cooling
Removing all clothing
Ice bath
Ice pack

**ADVERSE HEALTH EFFECTS ASSOCIATED
WITH
SYNTHETIC CANNABINOID USE —
MISSISSIPPI, 2015**

**PATIENT (OR
SURROGATE)
INTERVIEW**

Interviewer: _____ Agency: _____
Date:(mm/dd/yyyy): ____/____/____

NARRATIVE #1 – For Adults

My name is (YOUR NAME) and I'm from the Mississippi health department. We have recently seen an increase in people getting sick from synthetic marijuana. We want to learn why you and other people are getting sick, and how we can help prevent others from getting sick. You are free to choose if you want to participate in this survey. Also, you are free to skip any questions you do not wish to answer, and you may decide to end the interview at any time. Everything you say is confidential. Your name is not attached to any of your answers, and we do not report any of your information to the authorities. Would you be willing to take a few minutes to talk with us? *(If asked will take approximately 15-20 minutes to complete.)*

Yes No; *If "Yes," start questionnaire with Question 1.*

If "No," then read the Closing Statement on the last page.

NARRATIVE #2 – For Minors

My name is (YOUR NAME) and I'm from the Mississippi health department. We have recently seen an increase in people getting sick from synthetic marijuana. We want to learn why (PATIENT'S NAME) and other people are getting sick, and how we can help

prevent others from getting sick. We would like your permission to ask (PATIENT'S NAME) a few questions about this hospital visit. (PATIENT'S NAME) is free to choose if they want to participate in this survey. Also, (HE/SHE) is free to skip any questions they do not wish to answer, and (HE/SHE) may decide to end the interview at any time. Everything (HE/SHE) says is confidential. (HIS/HER) name is not attached to any of the answers, and we do not report any of their information to the authorities. Would you be willing to take a few minutes to talk with us? *(If asked will take approximately 15-20 minutes to complete.)*

Yes No; *If "Yes," start questionnaire with Question 1.*

If "No," then read the Closing Statement on the last page.

Public reporting burden of this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0920-1011)

SYNTHETIC MARIJUANA USE (GENERAL)

Now I am going to ask you questions about synthetic marijuana or *Spice* and other recreational drugs you may have used.

1. **Were you aware that over the past month many people in Mississippi have been getting sick after using synthetic marijuana?** Yes No
 Don't know Refused

1a. If yes: how did you find out? (Read options and check all that apply)

TV/Radio, specify _____

Social media (e.g. Facebook, Twitter, Instagram), specify _____

Internet website, (specify) _____

Friend

Family member

Other, (specify) _____

2. **Why do you choose to use synthetic marijuana?**

3. **How long have you been using synthetic marijuana?**

First time Less than 1 year More than 1 year Don't Know Refused

4. **How often did you use synthetic marijuana in the past 30 days?**

One time only (this episode) Less than once a week Once a week Several times a week
 Daily Don't know Refused

DETAILS OF SYNTHETIC MARIJUANA USE

Now I am going to ask some questions related to the synthetic marijuana product you used in the past 24 hours.

5. **What was the brand/street name of the synthetic marijuana product that you used in the past 24 hours?** Spice K2 Crazy Monkey
 Black Mamba Mojo Skunk
 Moon Rocks Yucatan Fire
 AK-47 Other

_____ Don't Know
 Refused

6. **Do you remember what the packaging looked like?:**

Yes, specify _____

_____ No Don't Know Refused

7. **Have you ever used <insert brand name from Q5> before?** Yes No Don't Know Refused

If No/Don't Know/Refused, skip to question 11

- 7a. If yes: how many times have you ever used <insert brand name from Q5>?** Once 2-5 times > 5 times Don't Know Refused

8. **Other than this time, have you ever gotten sick after using <insert brand name from Q5>?**

Yes No Don't Know Refused

9. **Did you notice anything different about this <insert brand name from Q5> (such as the appearance,**

taste, or smell) compared to other times you've used <insert brand name from Q5>? Yes No

_____ Don't Know Refused

- 9a. If yes: What did you notice was different?:** _____

10. **Did you notice anything different about how this <insert brand name from Q5> made you feel compared to other times you've used <insert brand name from Q5>?** Yes No Don't Know

_____ Refused

- 10a. If yes: What did you notice was different?:** _____

11. Why do you think you got sick this time?

12. How did you use this product in the past 24 hours? (Read options and check all that apply)

- Smoke Vaping Eat or Swallow
Snort Intravenous
Other _____
 Don't Know Refused

13. Was this different than the way you usually use it?

- Yes No Don't have normal method
 Don't Know Refused

14. Without giving a specific name, where did you get this product? (Read options and check all that apply)

- Convenience store/Gas station
Tobacco store/Head shop
 Bought from a dealer
From a friend or family member
 Internet
Party or Rave
 Other, specify _____

- Don't know Refused

15. Do you know if anyone else who used the same product as you got sick?

- Yes No Don't Know Refused
15a. If yes: Did they have to go to the hospital because of it? Yes No Don't Know Refused

16. In the past 24 hours, did you also use any street drugs or prescription drugs recreationally?

- Yes, specify _____

- No Don't Know Refused

Regarding Question 16 – Data entry team will categorize the drug name:

- Alcohol Tobacco Regular Marijuana
Heroin or Opioids Cocaine Methamphetamines
 Bath Salts Benzodiazepines Other, specify:

CLOSING QUESTIONS/COMMENT

17. What should we tell people about synthetic marijuana?

18. What's the best way to get the word out?

19. Notes or comments:

Closing Statement:

Thank you for your time. For your information, there have been reports of people getting sick after using synthetic marijuana in Mississippi. If you would like more information about synthetic marijuana, please contact Mississippi Poison Control Center at 1-800-222-1222, or go to the website -

[http://msdh.ms.gov/msdhsite/ static/23,16273,195.html](http://msdh.ms.gov/msdhsite/static/23,16273,195.html)