Serious and life-threatening events associated with non-medical (recreational) cannabis use in Canadian children and youth

CANADIAN PAEDIATRIC SURVEILLANCE PROGRAM
2305 St. Laurent Blvd. Ottawa, ON K1G 4J8
Tel: 613-526-9397, ext. 239
Fax: 613-526-3332
cpsp@cps.ca www.cpsp.cps.ca

REPORTING INFORMATION
(To be completed by the CPSP)

Report number:	
Month of reporting:	
Province:	
Today's date:	

Please complete the following sections for the case identified above.
Strict confidentiality of information will be assured.

CASE DEFINITION FOR SERIOUS AND LIFE-THREATENING EVENTS ASSOCIATED WITH NON-MEDICAL (RECREATIONAL) CANNABIS USE IN CANADIAN CHILDREN AND YOUTH

Report any child or adolescent less than 18 years of age (up to the 18th birthday) presenting with a new health condition or a deteriorating chronic/previously diagnosed condition resulting in either hospitalization (inpatient, intensive care unit, psychiatric), permanent disability, or death, which was likely primarily caused by the use of cannabis for non-medical purposes.

This includes either intentional or unintentional exposure to cannabis by a child or adolescent, or a condition resulting from use by another individual, such as a friend or a parent/caregiver, who is under the influence of cannabis.

Exclusion criteria

- A condition resulting from cannabis use for non-medical purposes during pregnancy/breastfeeding
- A condition resulting from cannabis use for medical purposes

SECTION 1 - PROVIDER

1.1 Which of the following best describes your practice?

☐ General paediatrician ☐ Paediatric subspecialist; specify: ____

☐ Other; specify: ________________________________

1.2 First 3 digits of the postal code of your practice: ___ ___ ___

1.3 Practice setting (check all that apply):

a) ☐ Urban ☐ Suburban ☐ Rural/Remote ☐ Does not apply

b) ☐ Academic ☐ Non-academic ☐ Does not apply

c) ☐ Medical inpatient hospital ward ☐ Intensive care unit (ICU) ☐ Psychiatric inpatient hospital ward
☐ Emergency department/Urgent care centre ☐ Other, specify: ____________________________________

SECTION 2 - CASE DEMOGRAPHIC INFORMATION

2.1 Date of birth: ____ /____ /______
DD MM YYYY

2.2 Sex: Male____ Female____

2.3 First 3 digits of patient's postal code: ___ ___ ___

SECTION 3 – CLINICAL PRESENTATION

3.1 Date of the reported event: ____ /____ /______
DD MM YYYY

3.2 Type of presenting condition:

☐ New/acute health condition ☐ Deterioration of chronic/previously diagnosed condition

3.3 What is the **primary** presenting condition (check **only one** category)?

☐ Unintentional injury *If yes*: ☐ Motor-vehicle related
If yes: ☐ Car ☐ ATV ☐ Motorcycle ☐ Other, specify:___________
☐ Fall ☐ Cut ☐ Drowning or near-drowning
☐ Poisoning/Intoxication (cannabis related)
☐ Other, specify: ____

☐ Intentional injury *If yes*: ☐ Attempted suicide ☐ Self-harm ☐ Uncertain
☐ Other, specify: ____

☐ Psychosis *If yes*: ☐ Drug-induced psychos *If yes*: ☐ First episode ☐ Recurrent
☐ Schizophrenia
☐ Other, specify____

☐ Affective/Anxiety disorder *If yes*: ☐ Depressive ☐ Bipolar ☐ Anxiety
☐ Other, specify____

☐ Gastrointestinal problem *If yes*: ☐ Cannabis hyperemesis syndrome
☐ Other, specify: ____

☐ Respiratory problem *If yes*: ☐ Asthma attack (bronchospasm) ☐ Respiratory depression
☐ Other, specify: ____

☐ Cardiovascular problem *If yes*: ☐ Syncope ☐ Ischemia/Infarcts
☐ Other, specify: ____

☐ Neurologic problem *If yes*: ☐ Seizure
☐ Other, specify: ____

☐ Cannabis-related disorders (DSM 5) *If yes :*
☐ Cannabis intoxication
☐ Cannabis withdrawal
☐ Other, specify: ____

☐ Other, specify: ____

SECTION 4 - TREATMENT AND OUTCOMES

4.1 Outcomes attributed to the reported condition (check all that apply):

☐ Hospitalization *If yes*, (check all that apply)*:* ☐ Inpatient bed ☐ ICU/PICU bed ☐ Psychiatric bed
Specify: Length of stay ________days ☐ Patient is still in the hospital
☐ Confirmed permanent disability *If yes*, specify: ____
☐ Possible permanent disability *If yes*, explain: ____
☐ Death

4.2 Treatment provided (check all that apply):

☐ Does not apply (death prior to hospital)
☐ Physical *If yes*, check all that apply:
☐ Adolescent medicine consultation
☐ Ventilation assistance *If yes*: ☐ Intubation ☐ Noninvasive
☐ Vasoactive drugs

☐ Blood transfusion, colloid solutions, or both
☐ Renal assistance (i.e., hemodialysis, hemofiltration, or both)
☐ Surgery *If yes*, specify: ______________________________
☐ Other, specify: ______________________________

☐ Mental/Psychosocial — *If yes*, check all that apply:
☐ Psychiatry consultation
☐ Other mental health professional
If yes, check all that apply: ☐ Psychologist ☐ Social worker ☐ Addiction worker ☐ Youth protection worker
☐ Other, specify: ______________________________

SECTION 5 - CAUSALITY

5.1 Regarding the primary presenting condition, cannabis use for non-medical (recreational) purposes was the (check only one): ☐ Possible cause ☐ Probable cause ☐ Definite cause

5.2 The primary condition resulted from (check only one):
☐ Primary exposure of the patient to cannabis (e.g., ingestion or inhalation)
☐ Secondary exposure of the patient to cannabis or its byproducts (e.g., second-hand smoke)
☐ Cannabis exposure by another individual (e.g., injury due to parent under the influence of cannabis)
If yes, exposure by: ☐ Parent ☐ Other caregiver ☐ Friend ☐ Other, specify: __________________

SECTION 6 - DETAILS OF CANNABIS EXPOSURE

6.1 Cannabis exposure (check only one): ☐ Intentional ☐ Unintentional ☐ Unknown

6.2 Cannabis product(s) acquired by (check all that apply): ☐ Patient ☐ Parent/caregiver ☐ Friend
☐ Other, specify: ____________________ ☐ Unknown

6.3 Was the product(s) acquired through (check all that apply): ☐ Legal retailers (i.e. provincial authorized stores)
☐ Authorized Licensed Producers of Cannabis for Medical Purposes (under the Access to Cannabis for Medical Purposes Regulations)
☐ Legally home grown/produced ☐ Illegal sources (e.g., on the street, unauthorized dispensaries)
☐ Unknown
If legally acquired, product(s) information:
Product name/potency:____________________________
Licensed producer:______________________________
Lot/batch:______________________________________
☐ Unknown

6.4 Route of exposure (check all that apply):
Ingestion: ☐ Yes ☐ No ☐ Unknown
Inhalation: ☐ Yes ☐ No *If yes,* (check all that apply): ☐ Smoking ☐ Vaping ☐ Dabbing
☐ Unknown ☐ Other, specify: _____________________

6.5 Product type: ☐ Marijuana (shredded buds and leaves)
☐ Hashish
☐ Cannabis oil
☐ Hash oil (including butane hash oil, BHO)
☐ Dabs (shatter, wax, budder)
☐ Cannabis tincture/extract
☐ Cannabis edibles (in food or candy), specify: ____________________________

☐ Other, specify: ____

☐ Unknown

6.6 Frequency of cannabis use: ☐ Does not apply (unintentional exposure)
☐ First use
☐ Prior history of use*, if yes specify:* ☐ Daily use ☐ Use at least once per week
☐ Use at least once per month
☐ Use less often than once per month
☐ Unknown

SECTION 7 - CO-EXPOSURE TO OTHER SUBSTANCES

7.1 Other substance(s) used/exposed to contributing to the occurrence of the reported condition (check all that apply):
☐ Alcohol ☐ Opioids ☐ Amphetamines/Ecstasy ☐ Benzodiazepines ☐ Cocaine
☐ Synthetic cannabinoids (“spice”) ☐ Tobacco/Cigarettes ☐ Other, specify: _______________________
☐ None ☐ Unsure/Unknown

SECTION 8 – LABORATORY DATA

8.1 Testing performed to prove exposure to cannabis:

Test	Conducted	Results	
Urine/qualitative technique	☐ Yes ☐ No ☐ Unknown ☐ Unavailable in my setting	*If yes*: ☐ Positive ☐ Negative ☐ Unknown	
Urine/quantitative technique	☐ Yes ☐ No ☐ Unknown ☐ Unavailable in my setting	*If yes*: ☐ Positive ☐ Negative ☐ Unknown	*If positive*, list results: __________________
Blood/quantitative technique	☐ Yes ☐ No ☐ Unknown ☐ Unavailable in my setting	*If yes*: ☐ Positive ☐ Negative ☐ Unknown	*If positive*, list results: __________________
Other, specify____		*If yes*: ☐ Positive ☐ Negative ☐ Unknown	*If positive*, list results: __________________

SECTION 9 – RELEVANT MEDICAL HISTORY

9.1 Prior hospitalization for a cannabis-related condition: ☐ Yes ☐ No ☐ Unknown

9.2 Significant past medical condition(s) contributing to the primary presenting condition (check all that apply):
☐ Psychiatric condition; specify: ____
☐ Cardiac; specify:____
☐ Respiratory; specify:____
☐ Neurologic; specify:____
☐ Other condition; specify:____
☐ Unknown

9.3 Any prescribed medication that may have contributed to the primary presenting condition
(report all that apply): ____

SECTION 10 - FURTHER INFORMATION

☐ I agree to be contacted by the CPSP for further information on this questionnaire.
☐ I do not wish to be contacted by the CPSP for further information on this questionnaire.

SECTION 11 - REPORTING PHYSICIAN

First name__________________ Surname____

Address____

City__________________________ Province/Territory_________________ Postal code ______________________________

Telephone number____________________________ Fax number____

E-mail______________________________________ Date completed ____

Thank you for completing this form.