

- 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	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Unavailable in my setting	<i>If yes:</i> <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown	
Urine/quantitative technique	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Unavailable in my setting	<i>If yes:</i> <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown	<i>If positive</i> , list results: _____
Blood/quantitative technique	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Unavailable in my setting	<i>If yes:</i> <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown	<i>If positive</i> , list results: _____
Other, specify _____		<i>If yes:</i> <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown	<i>If positive</i> , 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.