Suspected Synthetic Cannabinoid Coagulopathy Case Form

1. Name of patient (*First, Last*): ________________________________
2. Date of birth and sex of patient: DOB (*dd/mm/yyyy*): ____/_____/_______
3. Sex (*Circle*): M F
4. Race (*Circle all that apply):*
   White Black Amer. Indian/Alaska Native Asian Hawaiian Native/Pacific Islander
   Unknown Other:____
5. Ethnicity (*Circle*): Hispanic or Latino Non Hispanic or Non Latino Unknown
6. Home address of patient (*including county)*:
   Street____ City___________
   County______________ State____________ Zipcode____________
7. Contact number of patient, if known (*xxx-xxx-xxxx*): (_____)-_______-_________
8. Treating physician (*First, Last*):__________________________________
9. Contact number of physician: (*xxx-xxx-xxxx*): (_____)-_______-_________
10. Health care facility (*Name and Location*):____
11. Date of presentation to the facility (*dd/mm/yyyy*): ____/_____/_______
12. Date of symptoms onset (*dd/mm/yyyy*): ____/_____/_______
13. Reported symptoms:____
    ____
14. Initial INR value and date:
    Value: ______________________ Date (*dd/mm/yyyy*): ____/_____/_______
15. Current INR value and date:
    Value: ______________________ Date (*dd/mm/yyyy*): ____/_____/_______
16. Current treatment for elevated INR:
    ____
17. Does patient normally take anti-coagulants? *(Circle one)*
    Yes No Not sure
18. Was patient was exposed to a rodenticide or intentionally ingest an anti-coagulant? *(Circle one)*
    Yes No Not sure
19. Has patient used illicit drugs, including synthetic marijuana in the past 3 months? *(Circle one)*
    Yes (see below) No Not sure
    If yes, which drug(s)? ____
20. Was a urine toxicology screen run? *(Circle one)* *Yes No Not sure*
    If yes, please list any relevant findings: ____
    ____
21. What is current clinical status of patient? *(Check)* __ICU __Hospital __Discharged __Deceased
    Other:____
22. Has Ohio Poison Center been contacted?
    Yes No Not sure
    If yes, which date? (*dd/mm/yyyy*): ____/_____/_______
23. Other information on patient:
    ____
    ____

If you are a provider filling out this form, please contact the local public health department ***in jurisdiction in which patient resides to report suspected case. If patient residence is unknown, report to the local public health department in which the provider is located. Please contact your local health department or Amanda Okello, ODH Epidemiologist, at*** amanda.okello@odh.ohio.gov ***or 614-644-8311 with any questions.***