Medicinal Cannabis Control Commission

CHAIR Lisa Brunner VICE CHAIR Regina Murray COMMISSIONER Marcy Hart

Serious Adverse Incident Form

Registered patients, primary caregivers, and healthcare professionals must report to Waabigwan Mashkiki (manufacturer) within five (5) business days of the incident.

A Peace Officer must report any serious adverse incidents relating to overdose and any case of diversion involving an adverse incident within five (5) business days of the incident by calling the Medicinal Cannabis Control Commission. If part of an ongoing investigation, the report must be made within 72 hours of the conclusion of the investigation.

REPORT INFORMATION

Date of Report

Date of Adverse Incident

Relation to the Affected Individual

PERSONAL INFORMATION OF THE AFFECTED INDIVIDUAL

Full Name

First Name | Middle Initial | Last Name

Date of Birth

Month | Day | Year

Sex Assigned at Birth

- ☐ Male
- ☐ Female
- ☐ Intersex

Medicinal Cannabis Patient #

Affected Individual's Contact Information

Telephone/Cell Phone | Email | Occupation

SUSPECTED ITEM INFORMATION

Does the affected individual suspect that cannabis caused this adverse incident?

- ☐ Yes
- ☐ No
- ☐ Maybe

Is there a specific medicinal cannabis product that is suspected to have caused this adverse incident?

- ☐ Yes
- ☐ No

Please upload a photo of the product and/or packaging, and/or any other relevant files.

MEDICAL CONDITIONS

Please list all past or existing medical conditions.

Please list all prescription medications or other drugs taken near the time of the incident.

Does the affected individual use any of the following:

- ☐ Smoking Tobacco
- ☐ Electronic Cigarettes/Vaping Devices
- ☐ Dabbing Equipment
- ☐ No
- ☐ Unknown

Please check all symptoms related to this adverse incident:

- [ ] Diarrhea
- [ ] Blood in Sputum
- [ ] Fainting
- [ ] Nausea
- [ ] Constipation
- [ ] Anaphylaxis
- [ ] Skin Rash
- [ ] Edema
- [ ] Weakness
- [ ] Other
- [ ] Blood in Stool
- [ ] Fever
- [ ] Changes in Heart Rate
- [ ] Vomiting
- [ ] Jaundice
- [ ] Change in Blood Pressure
- [ ] Pain
- [ ] Numbness
- [ ] Difficulty Breathing
- [ ] None

CLINICAL INFORMATION

Was a healthcare provider visited to assess this adverse event or any of the associated symptoms?

- [ ] Yes
- [ ] No

OTHER EXPOSURES

Please check all that apply:

- [ ] Recent Travel
- [ ] Recent Consumption of Untreated Water
- [ ] Recent Exposure to Untreated Water
- [ ] Other Exposures

Has anyone else whom the affected individual has been in contact with experienced similar symptoms?

- [ ] Yes
- [ ] No

Does the affected individual care for an ill individual at home or do they visit healthcare centers frequently?

☐ Yes
☐ No

May we contact whoever submitted this form for more information?

☐ Yes
☐ No

Enter your email address here if you would like a copy of this submission.

Sign Here

Print Name

Sign Name

Date