pennsylvania
DEPARTMENT OF HEALTH

BUREAU OF MEDICAL MARIJUANA
REPORTING ADVERSE EVENTS MADE TO A DISPENSARY

This form must be submitted when a dispensary immediately becomes aware of any complaint made to the dispensary by a patient, caregiver or practitioner who reports an adverse event from using medical marijuana products purchased by the dispensary from a grower/processor or any devices or instruments purchased at the dispensary. A dispensary shall submit this form and any other documentation that may be required electronically to the Department.

Medical Marijuana Product Complaint Form

Section 1. Dispensary Information	
Dispensary Name:	Permit No.:
Facility Address:	
Person Completing Form:	
Phone Number:	
Date of Incident:	Date of Complaint:
Medical Professional (if a consult occurred)	Sales Clerk Number on packaging:

Section 2. Grower/processor Information		
Grower/processor Name:	Permit No.:	
Person Completing Form:		
Medical Marijuana Product Information		
Name of Product:	Product Doses:	
	Product Lot No:	
Product Species:	Date of Product:	
Product Strain:	Expiration Date:	
Device or Instrument Purchased at a Dispensary		
Name of Device:		
Name of Company:		
Other Identifying information (model, serial number, expiration date)		
Was someone operating the device when the problem occurred? Yes ☐ No ☐		
If yes, who was using it? ☐ The Patient ☐ A Caretaker ☐ Someone else (please explain who)		

Section 3. Patient Information
Person Providing the Patient Information: ☐ Patient ☐ Caregiver ☐ Medical Professional ☐ Other (please specify)
Patient Name:
Patient Address:
Patient phone Number:
Patient email:
Describe the complaint in the patient's words.
Was anyone else affected by the patient's use of the product? If yes, please explain.
Medical Marijuana Product Use **Attach a copy of the patient dosage instruction sheet**
What time of day was the product used?
What dosing amount did the patient use? (How much, how many doses?)
How often did the patient use the product over a 24-hour period?

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Section 4. Adverse Event Questions		
Type of adverse event. Please answer yes or no to the following.		
Did the event cause death? Yes ☐ No ☐	Was the event life threatening? Yes ☐ No ☐	Did the event require an emergency room visit? Yes ☐ No ☐
Did the event require hospitalization? Yes ☐ No ☐	Did the event result in disability? Yes ☐ No ☐	Did the event cause other serious medical issues? Yes ☐ No ☐

If medical attention was sought, please complete the questions below.			
Name and Contact Information of Doctor	Name:		
	Phone:		
How soon after taking the product did the patient contact the doctor?	______Minutes ______ Hours ______ Days _______ Weeks		
How long did the event last?	______Minutes ______ Hours ______ Days ______ Weeks		
Has the patient stop taking the medication?	Yes ☐ No ☐	If yes, when?	If no, why not?
Did the adverse event disappear after discontinuing use of the product?	Yes ☐ No ☐	How long after discontinuing use? ____Minutes ____Hours ____ Days ____ Weeks	
Are prescription or over the counter medications being used?	Yes ☐ No ☐	If yes, please list:	
Outcome of the adverse event?			

Section 5. Previous Product Complaints
Has the dispensary received any other complaints about the product? Yes ☐ No ☐ (If yes, please provide a summary of those complaints with dates.)

Section 6. Signatures	
Signature of individual completing the report at the dispensary.	
	Date:
Signature of individual receiving the report at the grower/processor.	
	Date: