PUBLIC HEALTH DIVISION
CENTER FOR HEALTH PROTECTION
Oregon Psilocybin Services
http://oregon.gov/psilocybin

OREGON HEALTH AUTHORITY

CLIENT ADVERSE REACTIONS

Instructions: Oregon Psilocybin Services (OPS) rules require facilitators to document certain client adverse reactions. Facilitators use this form for documentation, and the form must be stored in the client file and at a licensed service center in accordance with administrative rule requirements. This form is not submitted to OPS unless requested; however, OPS may request additional information for compliance purposes.

If Emergency Services were contacted, a separate additional Emergency Services Contact Report must be submitted within 48 hours of the event, and the service center must notify the emergency contact identified in the client's safety and support plan.

Definitions:

"Adverse behavioral reaction" means a client's behavioral reaction that required contacting emergency services or receiving care from a medical care provider that occurred during an administration session.

"Adverse medical reaction" means a client's medical reaction to that required contacting emergency services or receiving care from a medical care provider that occurred during an administration session.

"Severe adverse reaction" means an adverse behavioral reaction or medical reaction that requires a client to be transported to a hospital.

"Post-session reaction" means a medical or behavioral reaction occurring within 72 hours of the client's release from an administration session that was likely related to psilocybin consumption and resulted in contacting emergency services or the client receiving care from a medical care provider.

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Facilitator name: ______________________________________

Service Center name: ___________________________________

Client Name: ____

Date of administration session: ____________________________

Products consumed (type, dosage, quantity, and UID):

The client experienced an:

☐ Adverse behavioral reaction

☐ Adverse medical reaction

☐ Severe adverse behavioral reaction (transported to hospital)

☐ Severe adverse medical reaction (transported to hospital)

☐ Post-session reaction

Date of post-session reaction____________________

Were emergency services contacted? ☐ yes or no ☐

Emergency services contacted:______________________________________

Time emergency services were contacted:______________________________

Was the client transported by emergency services?

☐ yes or no ☐

If client was transported, indicate the address/location where the client was transported to: ____

If client was transported, did the facilitator or service center staff accompany the client?

☐ yes or no ☐

If the facilitator or service center staff accompanied the client, please provide details:

Was the person listed in the client's safety and support plan contacted?

☐ yes or no ☐

If yes, when were they contacted? _______________________________

Facilitator Signature: ___________________________Date: _____________