

## MedWatch 3500 Health Professional Report

The FDA Safety Information and Adverse Event Reporting Program

FDA Safety Report ID #	705349	FDA Received Date	04-Jun-2024
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<b>A. PATIENT INFORMATION</b>		
A1. Patient Identifier:	Unspecified	
A2. Age:	16	Year(s)
A2. Date of Birth:		
A3a. Sex: Enter the patient's sex at birth	Male	
	Female	Yes
	Undifferentiated	
	Decline to answer	
A3b. Gender: Enter the patient's current gender	Cisgender man/boy (gender corresponds with birth sex)	
	Cisgender woman/girl (gender corresponds with birth sex)	
	Transgender man/trans man/female-to-male (FTM)	
	Transgender woman/trans woman/male-to-female (MTF)	
	Other gender category; Please specify:	
	Decline to answer	
A4. Weight:	100	kg
A5. Ethnicity:	Hispanic/Latino	
	Not Hispanic/Latino	
A6. Race:	Asian	
	American Indian or Alaskan Native	
	Black or African American	
	White	
	Native Hawaiian or Other Pacific Islander	

<b>B. ADVERSE EVENT, PRODUCT PROBLEM</b>		
B1. Type of Report:	Adverse Event	Yes
	Product Use/Medication Error	
	Product Problem (e.g., defects/malfunctions)	
	Problem with Different Manufacturer of Same Medicine	
	Death ( <i>Date of Death</i> )	
B2. Outcome Attributed to Adverse Event:	Life-threatening	
	Hospitalization (initial or prolonged)	Yes
	Disability or Permanent Damage	
	Congenital Anomaly/Birth Defects	
	Other Serious or Important Medical Events	Yes
	Required Intervention to Prevent Permanent Impairment/Damage	
	B3. Date of Event:	01-Jun-2024
B4. Date of this Report:	04-Jun-2024	

**B5. Describe Event, Problem or Product Use/Medication Error:**

16-year-old ingested entire bar of Diamond Shrumz Premium Microdose Dark Chocolate Bar. EMS was called to scene after another patient ingested a bar also and had seized. EMS noted patient to be altered and vomited, while transporting to the ER she became very rigid, with seizure like activity. EMS administered 5mg IV versed. On arrival to ED, patient presented with rigidity and required intubation for airway protection, continued with versed and levetiracetam due to seizure activity. Head CT negative. Patient transferred to tertiary care center where she remained intubated and sedated until day 2. Patient continued with agitation and hallucinations and was medically cleared on day 3.

<b>B6. Relevant Tests/Laboratory Data:</b>	
Test 1	
Test Date:	
Test Name:	
Test Result:	
Test Unit:	
Low Test Range:	
High Test Range:	
Test 2	
Test Date:	
Test Name:	
Test Result:	
Test Unit:	
Low Test Range:	
High Test Range:	
Test 3	
Test Date:	
Test Name:	
Test Result:	
Test Unit:	
Low Test Range:	
High Test Range:	
Test 4	
Test Date:	
Test Name:	
Test Result:	
Test Unit:	
Low Test Range:	
High Test Range:	

<b>B6. Relevant Tests/Laboratory Data:</b>	
Test 5	
Test Date:	
Test Name:	
Test Result:	
Test Unit:	
Low Test Range:	
High Test Range:	
Test 6	
Test Date:	
Test Name:	
Test Result:	
Test Unit:	
Low Test Range:	
High Test Range:	
Test 7	
Test Date:	
Test Name:	
Test Result:	
Test Unit:	
Low Test Range:	
High Test Range:	
Test 8	
Test Date:	
Test Name:	
Test Result:	
Test Unit:	
Low Test Range:	
High Test Range:	

B6. Additional Comments:

B7. Other Relevant History, Including Preexisting Medical Conditions:

**C. PRODUCT AVAILABILITY**

C1. Product Available for Evaluation?	No
C1. Returned to Manufacturer on:	
C2. Do you have a picture of the product?	Yes

**D. SUSPECT PRODUCTS**

Product 1

D1. This report involves:	Cosmetic				
	Dietary supplement				
	Food/medical food	Yes			
	Other				
D1. Name:	Diamond Shrumz Premium Microdose Chocolate- Dark Chocolate Bar				
D1. Strength:					
D1. Manufacturer/Compounder:	Prophet Premium Blends				
D1. NDC # or Unique ID:					
D1. Lot #:	Batch: 0012				
D2. Dose or Amount:	45.4	GM			
D2. Frequency:					
D2. Route:	Oral				
D3. Treatment Dates/Therapy Dates:	Start	Stop		Dose Reduced	
	Give best estimate of duration				
	Is therapy still on-going?				
D4. Diagnosis for Use:					
D5. Product Type:	OTC (Over-the-counter)	Yes			
	Compounded				
	Generic				
	Biosimilar				
D6. Expiration Date:	01-Jun-2025				
D7. Event Abated After Use Stopped or Dose Reduced?	Doesn't apply				
D8. Event Reappeared After Reintroduction?	Doesn't apply				

Product 2

D1. This report involves:	Cosmetic				
	Dietary supplement				
	Food/medical food				
	Other				
D1. Name:					
D1. Strength:					
D1. Manufacturer/Compounder:					
D1. NDC # or Unique ID:					
D1. Lot #:					
D2. Dose or Amount:					
D2. Frequency:					
D2. Route:					
D3. Treatment Dates/Therapy Dates:	Start	Stop		Dose Reduced	
	Give best estimate of duration				
	Is therapy still on-going?				
D4. Diagnosis for Use:					
D5. Product Type:	OTC (Over-the-counter)				
	Compounded				
	Generic				
	Biosimilar				
D6. Expiration Date:					
D7. Event Abated After Use Stopped or Dose Reduced?					
D8. Event Reappeared After Reintroduction?					

E. SUSPECT MEDICAL DEVICE		
E1. Brand Name:	N/A	
E2a. Common Device Name:		
E2b. Procode:		
E3. Manufacturer Name, City and State:		
E4. Model #:		
E4. Catalog #:		
E4. Serial #:		
E4. Lot #:		
E4. Expiration Date:		
E4. Unique Device Identifier (UDI) #:		
E5. Operator of Device:	Health Professional	
	Patient/Consumer	
	Other	
E6a. If Implanted, Give Date:		
E6b. If Explanted, Give Date:		
E7a. Is this a single-use device that was reprocessed and reused on a patient?		
E7b. If Yes to Item 7a, Enter Name and Address of Reprocessor:		
E8. Was this device serviced by a third party servicer?		

F. OTHER (CONCOMITANT) MEDICAL PRODUCTS

Product Name	Therapy Start Date	Therapy End Date
1.		
2.		
3.		
4.		
5.		
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7.		
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13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		
21.		

G. REPORTER		
G1. Name and Address	Last Name	(b) (6)
	First Name	(b) (6)
	Address	
	City	
	State/Province/Region	
	ZIP/Postal Code	
	Country	
	Phone #:	(b) (6)
Email:	(b) (6)	
G2. Health Professional?	Yes	
G3. Occupation:	Nurse	
G4. Also Reported To:	Manufacturer/Compounder	
	User Facility	
	Distributer/Importer	
G5. If you do NOT want your identity disclosed to the manufacturer, place an "X" in this box (Confidentiality Requested):	Yes	

## ⚠️ WARNINGS AND DISCLAIMERS

- Never attempt to operate any form of heavy machinery or moving vehicle while using this product.
- Intoxicating effects of this product may be delayed.
- Warning: if consumed, may cause drowsiness.
- Warning: if consumed, may cause spiritual experience.
- Consult a doctor before consuming this product.
- Do not use this product if you are pregnant or nursing.
- 21 and over only!
- KEEP AWAY FROM CHILDREN AND PETS.

### THIS IS NOT AN FDA APPROVED PRODUCT

These statements have not been evaluated by the FDA. This product is not intended to diagnose, treat, cure, or prevent any disease. The purchaser of this product bears all risk and assumes all liability associated with the use, purchase, and possession of this product.

### INGREDIENTS

Cocoa Mass, Soy Lecithin, Sugar, Cocoa Butter, Milk, Corn Syrup, Cornstarch, Artificial Coloring, MCT Oil, Quantum Kava Liposome, Ashwagandha Extract, GABA, 5-HTP, Phosphatidylcholine, Caffeine Anhydrous, Muscimol, Lions Mane Mushroom Extract (Standardized to 30% Polysaccharides), Reishi Mushroom Extract, Chaga Mushroom Extract, and Rhodiola Rosea Extract.

#### DISTRIBUTED BY:

Prophet Premium Blends  
2413 S. Broadway  
Santa Ana, CA 92707

DIAMONDSHRUMZ.COM



LAB TESTED



7 55003 85882 9  
Batch: 0012  
Expiration Date: June, 2025

For more information and resources for National Child Abuse Prevention Month, visit [childabusepreventionmonth.org](http://www.childabusepreventionmonth.org).  
From the Children's Bureau, visit [childwelfare.gov/preventionmonth](http://www.childwelfare.gov/preventionmonth).

23-35013-24-23

LEADING FORM OF MICRODOSING

ENHANCED  
INGREDIENTS

DIAMOND™  
**SHRUUMZ**

PREMIUM MICRODOSE CHOCOLATE

DARK CHOCOLATE BAR  
15 PIECE NET WEIGHT 1.6 OZ



Yellow Isolation

PRO GEAR

8 52212 00

## MedWatch 3500 Health Professional Report

The FDA Safety Information and Adverse Event Reporting Program

FDA Safety Report ID #	705372	FDA Received Date	04-Jun-2024
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<b>A. PATIENT INFORMATION</b>		
A1. Patient Identifier:	Unspecified	
A2. Age:	15	Year(s)
A2. Date of Birth:		
A3a. Sex: Enter the patient's sex at birth	Male	
	Female	Yes
	Undifferentiated	
	Decline to answer	
A3b. Gender: Enter the patient's current gender	Cisgender man/boy (gender corresponds with birth sex)	
	Cisgender woman/girl (gender corresponds with birth sex)	
	Transgender man/trans man/female-to-male (FTM)	
	Transgender woman/trans woman/male-to-female (MTF)	
	Other gender category; Please specify:	
	Decline to answer	
A4. Weight:	69.9	kg
A5. Ethnicity:	Hispanic/Latino	
	Not Hispanic/Latino	
A6. Race:	Asian	
	American Indian or Alaskan Native	
	Black or African American	
	White	
	Native Hawaiian or Other Pacific Islander	

<b>B. ADVERSE EVENT, PRODUCT PROBLEM</b>		
B1. Type of Report:	Adverse Event	Yes
	Product Use/Medication Error	
	Product Problem (e.g., defects/malfunctions)	
	Problem with Different Manufacturer of Same Medicine	
	Death ( <i>Date of Death</i> )	
B2. Outcome Attributed to Adverse Event:	Life-threatening	
	Hospitalization (initial or prolonged)	Yes
	Disability or Permanent Damage	
	Congenital Anomaly/Birth Defects	
	Other Serious or Important Medical Events	Yes
	Required Intervention to Prevent Permanent Impairment/Damage	
	B3. Date of Event:	02-Jun-2024
B4. Date of this Report:	04-Jun-2024	

**B5. Describe Event, Problem or Product Use/Medication Error:**

15 year old ingested entire bar of Diamond Shrumz Premium Microdose Chocolate- Dark Chocolate Bar, became altered and seized. EMS transported to ED, patient had lower extremity clonus and required intubation to protect her airway. Transferred to tertiary care center and admitted to ICU. Was extubated on Day 2, continued to have agitation and hallucinations which resolved. Patient was medically cleared and discharged from the ICU on day 3.

<b>B6. Relevant Tests/Laboratory Data:</b>	
Test 1	
Test Date:	
Test Name:	
Test Result:	
Test Unit:	
Low Test Range:	
High Test Range:	
Test 2	
Test Date:	
Test Name:	
Test Result:	
Test Unit:	
Low Test Range:	
High Test Range:	
Test 3	
Test Date:	
Test Name:	
Test Result:	
Test Unit:	
Low Test Range:	
High Test Range:	
Test 4	
Test Date:	
Test Name:	
Test Result:	
Test Unit:	
Low Test Range:	
High Test Range:	

<b>B6. Relevant Tests/Laboratory Data:</b>	
Test 5	
Test Date:	
Test Name:	
Test Result:	
Test Unit:	
Low Test Range:	
High Test Range:	
Test 6	
Test Date:	
Test Name:	
Test Result:	
Test Unit:	
Low Test Range:	
High Test Range:	
Test 7	
Test Date:	
Test Name:	
Test Result:	
Test Unit:	
Low Test Range:	
High Test Range:	
Test 8	
Test Date:	
Test Name:	
Test Result:	
Test Unit:	
Low Test Range:	
High Test Range:	

B6. Additional Comments:

B7. Other Relevant History, Including Preexisting Medical Conditions:

**C. PRODUCT AVAILABILITY**

C1. Product Available for Evaluation?	No
C1. Returned to Manufacturer on:	
C2. Do you have a picture of the product?	Yes

**D. SUSPECT PRODUCTS**

Product 1

D1. This report involves:	Cosmetic				
	Dietary supplement				
	Food/medical food	Yes			
	Other				
D1. Name:	Diamond Shrumz Premium Microdose Chocolate- Dark Chocolate Bar				
D1. Strength:					
D1. Manufacturer/Compounder:	Prophet Premium Blends				
D1. NDC # or Unique ID:					
D1. Lot #:	Batch: 0012				
D2. Dose or Amount:	45.35	GM			
D2. Frequency:					
D2. Route:	Oral				
	Start	Stop		Dose Reduced	
D3. Treatment Dates/Therapy Dates:	Give best estimate of duration				
	Is therapy still on-going?				
D4. Diagnosis for Use:					
	OTC (Over-the-counter)	Yes			
D5. Product Type:	Compounded				
	Generic				
	Biosimilar				
D6. Expiration Date:					
D7. Event Abated After Use Stopped or Dose Reduced?					
D8. Event Reappeared After Reintroduction?					

Product 2

D1. This report involves:	Cosmetic				
	Dietary supplement				
	Food/medical food				
	Other				
D1. Name:					
D1. Strength:					
D1. Manufacturer/Compounder:					
D1. NDC # or Unique ID:					
D1. Lot #:					
D2. Dose or Amount:					
D2. Frequency:					
D2. Route:					
	Start	Stop		Dose Reduced	
D3. Treatment Dates/Therapy Dates:	Give best estimate of duration				
	Is therapy still on-going?				
D4. Diagnosis for Use:					
	OTC (Over-the-counter)				
D5. Product Type:	Compounded				
	Generic				
	Biosimilar				
D6. Expiration Date:					
D7. Event Abated After Use Stopped or Dose Reduced?					
D8. Event Reappeared After Reintroduction?					

E. SUSPECT MEDICAL DEVICE		
E1. Brand Name:	N/A	
E2a. Common Device Name:		
E2b. Procode:		
E3. Manufacturer Name, City and State:		
E4. Model #:		
E4. Catalog #:		
E4. Serial #:		
E4. Lot #:		
E4. Expiration Date:		
E4. Unique Device Identifier (UDI) #:		
E5. Operator of Device:	Health Professional	
	Patient/Consumer	
	Other	
E6a. If Implanted, Give Date:		
E6b. If Explanted, Give Date:		
E7a. Is this a single-use device that was reprocessed and reused on a patient?		
E7b. If Yes to Item 7a, Enter Name and Address of Reprocessor:		
E8. Was this device serviced by a third party servicer?		

F. OTHER (CONCOMITANT) MEDICAL PRODUCTS

Product Name	Therapy Start Date	Therapy End Date
1.		
2.		
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21.		

G. REPORTER		
G1. Name and Address	Last Name	(b) (6)
	First Name	(b) (6)
	Address	
	City	
	State/Province/Region	
	ZIP/Postal Code	
	Country	
	Phone #:	
Email:		
G2. Health Professional?	Yes	
G3. Occupation:	Nurse	
G4. Also Reported To:	Manufacturer/Compounder	
	User Facility	
	Distributer/Importer	
G5. If you do NOT want your identity disclosed to the manufacturer, place an "X" in this box (Confidentiality Requested):	No	

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#### DISTRIBUTED BY:

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2413 S. Broadway  
Santa Ana, CA 92707

DIAMONDSHRUMZ.COM



LAB TESTED



7 55003 85882 9  
Batch: 0012  
Expiration Date: June, 2025

For more information and resources for National Child Abuse Prevention Month  
from the Children's Bureau, visit [childabuseprevention.gov/preventionmonth](http://childabuseprevention.gov/preventionmonth).

23-35013-24-23

LEADING FORM OF MICRODOSING

ENHANCED  
INGREDIENTS

DIAMOND™  
**SHRUUMZ**

PREMIUM MICRODOSE CHOCOLATE

DARK CHOCOLATE BAR  
15 PIECE NET WEIGHT 1.6 OZ



Yellow Isolation

PRO GEAR

8 52212 00

All dates displayed in the report are in EST(GMT-05:00) time zone

**Basic Details**

Company Unit	CDER-CTU	Originating Account	FAERS
Source Medium	MWO (Drug)	Source Form Type	E2B XML 3500
Priority	Routine		
Override Auto Calculation Rule	No		
FDA Received Date	06-Jun-2024	CTU Received Date	06-Jun-2024
CTU Triage Date		CTU Data Entry Date	
Report Type	Spontaneous	Report Classification	Drug
Assign To	User		
User/Group			
Forward to Department	<input checked="" type="checkbox"/> CDER (CDER-OSE-RSS-CTU@fda.hhs.gov) (E2B)		
Case Priority	Direct		

**Contact**

Case Reporter	First Name	Last Name	Email Address	Phone
<input checked="" type="checkbox"/>	(b) (6)	(b) (6)	(b) (6)	(b) (6)

**A. PATIENT INFORMATION**

Patient Identifier (In Confidence)	(b) (6)
Age	21 Year(s)
Date of Birth	
Sex	Female
Gender	Decline to answer
Please Specify Other Gender	
Weight	
Ethnicity (Check single best answer)	
Race (Check all that apply)	<input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian or Other Pacific Islander

**B. ADVERSE EVENT, PRODUCT PROBLEM**

Type of Report (check all that apply)	<input checked="" type="checkbox"/> Adverse Event <input type="checkbox"/> Product Use/Medication Error <input type="checkbox"/> Product Problem (e.g., defects/malfunctions) <input type="checkbox"/> Problem with Different Manufacturer of Same Medicine
Serious	Yes
Outcome Attributed to Adverse Event (Check all that apply)	<input type="checkbox"/> Death <input type="checkbox"/> Life Threatening <input checked="" type="checkbox"/> Hospitalization (initial or prolonged) <input checked="" type="checkbox"/> Other Serious or Important Medical Events <input type="checkbox"/> Disability or Permanent Damage

<input type="checkbox"/>	Congenital Anomaly/Birth Defects
<input checked="" type="checkbox"/>	Required Intervention to Prevent Permanent Impairment/Damage

Date of Death	
Date of Event	30-May-2024
Date of this Report	06-Jun-2024

**Describe Event, Problem or Product Use Error**

Describe Event, Problem, or Product Use Error: 21 y.o. Female arrived to Emergency Department yesterday (05-30-2024) at 1545 after ingesting #2 Diamond Shrumz cones. Pt was twitching on arrival, possible seizures. Was nonverbal and not following commands, nonresponsive to naloxone. Pt was intubated, sedated. Patient was extubated and returned to baseline prior to time of call 5/31/2024 at 10:45 AM. All vitals and labs remained unremarkable. [https://diamondshrumz.com/wp-content/uploads/sites/12/shrmz-cones\[INVALID\]s-cream.pdf](https://diamondshrumz.com/wp-content/uploads/sites/12/shrmz-cones[INVALID]s-cream.pdf)

**Relevant Test/Laboratory Data**

1 of 1

Test Name		Test Date	
Test Result		Test Unit	
Low Test Range		High Test Range	
More Information Available?			

**Additional Comments**

--

**Other Relevant History, Including Preexisting Medical Conditions**

Substance Use Disorder but reported to have been "clean" for 9 months.
--

**C. PRODUCT AVAILABILITY**

Product Available for Evaluation? (Do not send product to FDA)	No
Returned to Manufacturer on	
Do you have a picture of the product? (check yes if you are including a picture)	No

**D. PRODUCT(S)**

1 of 1

Suspect	Yes
Primary?	Yes
Type	Drug/Biologic
This report involves:	Other

**Name, Strength, Manufacturer/Compounder (from product label)**

Product Name	Diamond Shrumz	
Strength		If Other
Manufacturer/Compounder		
NDC# or Unique ID		

	Product Type(check all that apply)	<input checked="" type="checkbox"/> OTC <input type="checkbox"/> Compounded <input type="checkbox"/> Generic <input type="checkbox"/> Biosimilar	
--	------------------------------------	---	--

	Event Abated After Use Stopped or Dose Reduced?	Doesn't Apply	
--	---	---------------	--

	Event Reappeared after Reintroduction ?		
--	---	--	--

### Drug Therapy 1 of 1

Dose or Amount		If Other	
Frequency		If Other	
Route	Oral	If Other	
Dosage Form			
Start			
Stop			
Dose Reduced			
Therapy Duration		If Other	
Is therapy still on-going?			
Lot Number			
Expiration Date			

### Diagnosis for Use (indication) 1 of 1

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### E. SUSPECT MEDICAL DEVICE

Brand Name		
Common Device Name		
Procode		
Manufacturer Name		
City		
State		
Model #		
Lot #		
Catalog #		
Expiration Date		
Serial #		
Unique Identifier (UDI) #		
Operator of Device	<input type="checkbox"/> Health Professional <input type="checkbox"/> Patient/Consumer <input type="checkbox"/> Other	
Other		
If Implanted, Give Date		
If Explanted, Give Date		

	Is this a single-use device that was reprocessed and reused on a patient?	
	If Yes for the above field, Enter Name and Address of Reprocessor	
	Was this device serviced by a third party?	

**F. OTHER (CONCOMITANT) MEDICAL PRODUCTS****CONCOMITANT MEDICAL PRODUCT DESCRIPTION**

--	--

**G. REPORTER**

1 of 1

Primary?	Yes	
Reporter is Patient?		
Title		
Last Name	(b) (6)	
Middle Name		
First Name	(b) (6)	
Address	(b) (6)	
City	(b) (6)	
State/Province/Region	(b) (6)	
Country	UNITED STATES	If Other
ZIP/Postal Code	(b) (6)	
Phone	(b) (6)	
Email	(b) (6)	
Fax		
Reporter Organization		
Department		
Reporter Speciality		
Health Professional?	Yes	
Occupation	Nurse	If Other
Also Reported to	<input type="checkbox"/> Manufacturer/Compounder <input type="checkbox"/> User Facility <input type="checkbox"/> Distributor/Importer	
If you do NOT want your identity disclosed to the manufacturer	Yes	

All dates displayed in the report are in EST(GMT-05:00) time zone

**Basic Details**

Company Unit	CDER-CTU	Originating Account	FAERS
Source Medium	MWO (Drug)	Source Form Type	E2B XML 3500B
Priority	Routine		
Override Auto Calculation Rule	No		
FDA Received Date	08-Jun-2024	CTU Received Date	08-Jun-2024
CTU Triage Date		CTU Data Entry Date	
Report Type	Spontaneous	Report Classification	Drug
Assign To	User		
User/Group			
Forward to Department	<input checked="" type="checkbox"/>		
Case Priority	Direct		

**Contact**

Case Reporter	First Name	Last Name	Email Address	Phone
<input checked="" type="checkbox"/>	(b) (6)	(b) (6)	(b) (6)	(b) (6)

**Section A - About the Problem**

What kind of problem was it? (Check all that apply)	<input checked="" type="checkbox"/> Were hurt or had a bad side effect (including new or worsening symptoms) <input type="checkbox"/> Used a product incorrectly which could have or led to a problem <input type="checkbox"/> Noticed a problem with the quality of the product <input type="checkbox"/> Had problems after switching from one product maker to another maker
Date the problem occurred	06-Apr-2024
Serious	Yes
Did any of the following happen? (Check all that apply)	<input type="checkbox"/> Hospitalization - admitted or stayed longer <input type="checkbox"/> Required help to prevent permanent harm <input type="checkbox"/> Disability or health problem <input type="checkbox"/> Birth defect <input type="checkbox"/> Life-threatening <input type="checkbox"/> Death <input checked="" type="checkbox"/> Other serious/important medical incident(Please Describe Below)
Other serious/important medical incident(Please Describe Below)	

4. Tell us what happened and how it happened (Include as many details as possible FDA may reach out to you for any additional documents if necessary)

After consuming Diamond Shrumz Chocolate, lost consciousness, potentially seized, and caused lacerations due to falls associated with loss of consciousness. After effects include essential tremors potentially triggered by event.
--

**Relevant Test/Laboratory Data**

1 of 1

Test Name		Test Date	06-Apr-2024
Test Result		Test Unit	

Low Test Range		High Test Range	
More Information Available?			

**Additional Comments**

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**Section B - Product Availability**

Do you still have the product in case we need to evaluate it?	No
Do you have a picture of the product? (check yes if you are including a picture)	No

**Section C - About the Products**

1 of 1

Suspect	Yes		
Primary?	Yes		
Type	Drug/Biologic		
This report is about	Dietary Supplement		
Name of the product as it appears on the box, bottle, or package (Include as many names as you see)	Diamond Shrumz Chocolate Bar Dark Chocolate		
Name of the company that makes (or compounds) the product			
Product Type(check all that apply)	<input checked="" type="checkbox"/> Over-the-Counter <input type="checkbox"/> Compounded by a Pharmacy or an Outsourcing Facility <input type="checkbox"/> Generic <input type="checkbox"/> Biosimilar		
Strength		If Other	
NDC number			
Did the problem stop after the person reduced the dose or stopped taking or using the product?			
Did the problem return if the person started taking or using the product again?			

**Drug Therapy**

1 of 1

Expiration date			
Lot number			
Dosage Form			
Quantity		If Other	
Frequency		If Other	
How was it taken or used		If Other	
Date the person first started taking or using the product	01-Dec-2023		

Date the person stopped taking or using the product	06-Apr-2024
Date the person reduced dose of the product	
Give best estimate of duration	
Is therapy still on-going?	
Why was the person using the product? (such as what condition was it supposed to treat) <span style="float: right;">1 of 1</span>	

Returned to Manufacturer On	
-----------------------------	--

Section D - About the Medical Device	
Name of medical device	
Name of the company that makes the medical device	
Other identifying information (The model, catalog, lot, serial, or UDI number, and the expiration date, if you can locate them)	
Model Number	
Catalog Number	
Lot Number	
Serial Number	
UDDI Number	
Expiration date	
Was someone operating the medical device when the problem occurred?	

For implanted medical devices ONLY (such as pacemakers, breast implants, etc.)		
Date the implant was put in		Date the implant was taken out (If relevant)

Section E - About the Person Who Had the Problem	
Person's Initials	(b) (6)
Sex	Male
Gender	Cisgender man/boy
Please Specify Other Gender	
Age (specify unit of time for age)	
Date of Birth	(b) (6)
Weight	101.25 kg
Ethnicity (Choose only one)	Not Hispanic/Latino
Race (Check all that apply)	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander

- |                                     |                           |
|-------------------------------------|---------------------------|
| <input type="checkbox"/>            | Asian                     |
| <input checked="" type="checkbox"/> | White                     |
| <input type="checkbox"/>            | Black or African American |

List known medical conditions (Such as diabetes, high blood pressure, cancer, heart disease, or others)

--	--

Please list all allergies (such as to drugs, foods, pollen or others)

--	--

List any other important information about the person (such as smoking, pregnancy, alcohol use, etc.)

Infrequent alcohol consumption	
--------------------------------	--

List all current prescription medications and medical devices being used.

--	--

List all over-the-counter medications and any vitamins, minerals, supplements, and herbal remedies being used.

--	--

Section F - About the Person Filling Out This Form

1 of 1

Primary?	Yes
Reporter is Patient?	
Title	
Last name	(b) (6)
Middle Name	
First name	(b) (6)
Number/Street	
City	
State/Province	
Country	UNITED STATES
ZIP or Postal code	
Telephone number	(b) (6)
Email address	(b) (6)

Fax	
Reporter Organization	
Department	
Reporter Speciality	
Today's date	08-Jun-2024
Did you report this problem to the company that makes the product (the manufacturer/compounder)?	No
If you do NOT want your identity disclosed to the manufacturer, please mark this box (Confidentiality Requested):	No

All dates displayed in the report are in EST(GMT-05:00) time zone

**Basic Details**

Company Unit	CDER-CTU	Originating Account	FAERS
Source Medium	MWO (Drug)	Source Form Type	E2B XML 3500
Priority	Routine		
Override Auto Calculation Rule	No		
FDA Received Date	10-Jun-2024	CTU Received Date	10-Jun-2024
CTU Triage Date		CTU Data Entry Date	
Report Type	Spontaneous	Report Classification	Drug
Assign To	User		
User/Group			
Forward to Department	<input checked="" type="checkbox"/>		
Case Priority	Direct		

**Contact**

Case Reporter	First Name	Last Name	Email Address	Phone
<input checked="" type="checkbox"/>	(b) (6)	(b) (6)	(b) (6)	(b) (6)

**A. PATIENT INFORMATION**

Patient Identifier (In Confidence)	Unspecified
Age	
Date of Birth	(b) (6)
Sex	Male
Gender	Cisgender man/boy
Please Specify Other Gender	
Weight	
Ethnicity (Check single best answer)	Not Hispanic/Latino
Race (Check all that apply)	<input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> White <input type="checkbox"/> Native Hawaiian or Other Pacific Islander

**B. ADVERSE EVENT, PRODUCT PROBLEM**

Type of Report (check all that apply)	<input checked="" type="checkbox"/> Adverse Event <input type="checkbox"/> Product Use/Medication Error <input type="checkbox"/> Product Problem (e.g., defects/malfunctions) <input type="checkbox"/> Problem with Different Manufacturer of Same Medicine
Serious	Yes
Outcome Attributed to Adverse Event (Check all that apply)	<input type="checkbox"/> Death <input type="checkbox"/> Life Threatening <input checked="" type="checkbox"/> Hospitalization (initial or prolonged) <input type="checkbox"/> Other Serious or Important Medical Events <input type="checkbox"/> Disability or Permanent Damage

- |                          |  |
|--------------------------|--|
| <input type="checkbox"/> | Congenital Anomaly/Birth Defects                             |
| <input type="checkbox"/> | Required Intervention to Prevent Permanent Impairment/Damage |

Date of Death	
Date of Event	09-Jun-2024
Date of this Report	10-Jun-2024

**Describe Event, Problem or Product Use Error**

Describe Event, Problem, or Product Use Error: Patient ate an entire Diamond Shrumz chocolate bar. Some time later, he presented to a local ED with agitation, hallucinations, tachycardia, hypertension, and metabolic acidosis.

**Relevant Test/Laboratory Data**

1 of 1

Test Name		Test Date	
Test Result		Test Unit	
Low Test Range		High Test Range	
More Information Available?			

**Additional Comments**

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**Other Relevant History, Including Preexisting Medical Conditions**

No known medical history	
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**C. PRODUCT AVAILABILITY**

Product Available for Evaluation? (Do not send product to FDA)	No
Returned to Manufacturer on	
Do you have a picture of the product? (check yes if you are including a picture)	No

**D. PRODUCT(S)**

1 of 1

Suspect	Yes	
Primary?	Yes	
Type	Drug/Biologic	
This report involves:	Other	

**Name, Strength, Manufacturer/Compounder (from product label)**

Product Name	Diamond Shrumz	
Strength		If Other
Manufacturer/Compounder		
NDC# or Unique ID		

	Product Type(check all that apply)	<input type="checkbox"/> OTC <input type="checkbox"/> Compounded <input type="checkbox"/> Generic <input type="checkbox"/> Biosimilar	
	Event Abated After Use Stopped or Dose Reduced?	Doesn't Apply	
	Event Reappeared after Reintroduction ?	Doesn't Apply	

### Drug Therapy 1 of 1

Dose or Amount	1 TOT - Total	If Other	
Frequency		If Other	
Route	Oral	If Other	
Dosage Form			
Start	10-Jun-2024		
Stop			
Dose Reduced			
Therapy Duration		If Other	
Is therapy still on-going?	Yes		
Lot Number			
Expiration Date			

### Diagnosis for Use (indication) 1 of 1

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### E. SUSPECT MEDICAL DEVICE

Brand Name	
Common Device Name	
Procode	
Manufacturer Name	
City	
State	
Model #	
Lot #	
Catalog #	
Expiration Date	
Serial #	
Unique Identifier (UDI) #	
Operator of Device	<input type="checkbox"/> Health Professional <input type="checkbox"/> Patient/Consumer <input type="checkbox"/> Other
Other	
If Implanted, Give Date	
If Explanted, Give Date	

Is this a single-use device that was reprocessed and reused on a patient?	
If Yes for the above field, Enter Name and Address of Reprocessor	
Was this device serviced by a third party?	

**F. OTHER (CONCOMITANT) MEDICAL PRODUCTS****CONCOMITANT MEDICAL PRODUCT DESCRIPTION**

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**G. REPORTER**

1 of 1

Primary?	Yes	
Reporter is Patient?		
Title		
Last Name	(b) (6)	
Middle Name		
First Name	(b) (6)	
Address	(b) (6)	
City	(b) (6)	
State/Province/Region	(b) (6)	
Country	UNITED STATES	If Other
ZIP/Postal Code	(b) (6)	
Phone	(b) (6)	
Email	(b) (6)	
Fax		
Reporter Organization		
Department		
Reporter Speciality		
Health Professional?	Yes	
Occupation	Pharmacist	If Other
Also Reported to	<input type="checkbox"/> Manufacturer/Compounder <input type="checkbox"/> User Facility <input type="checkbox"/> Distributor/Importer	
If you do NOT want your identity disclosed to the manufacturer	Yes	

All dates displayed in the report are in EST(GMT-05:00) time zone

**Basic Details**

Company Unit	CDER-CTU	Originating Account	FAERS
Source Medium	MWO (Drug)	Source Form Type	E2B XML 3500B
Priority	Routine		
Override Auto Calculation Rule	No		
FDA Received Date	11-Jun-2024	CTU Received Date	11-Jun-2024
CTU Triage Date		CTU Data Entry Date	
Report Type	Spontaneous	Report Classification	Drug
Assign To	User		
User/Group			
Forward to Department	<input checked="" type="checkbox"/>		
Case Priority	Direct		

**Contact**

Case Reporter	First Name	Last Name	Email Address	Phone
<input checked="" type="checkbox"/>	(b) (6)	(b) (6)	(b) (6)	

**Section A - About the Problem**

What kind of problem was it? (Check all that apply)	<input checked="" type="checkbox"/> Were hurt or had a bad side effect (including new or worsening symptoms) <input type="checkbox"/> Used a product incorrectly which could have or led to a problem <input type="checkbox"/> Noticed a problem with the quality of the product <input type="checkbox"/> Had problems after switching from one product maker to another maker
Date the problem occurred	20-May-2024
Serious	Yes
Did any of the following happen? (Check all that apply)	<input checked="" type="checkbox"/> Hospitalization - admitted or stayed longer <input type="checkbox"/> Required help to prevent permanent harm <input type="checkbox"/> Disability or health problem <input type="checkbox"/> Birth defect <input type="checkbox"/> Life-threatening <input type="checkbox"/> Death <input type="checkbox"/> Other serious/important medical incident(Please Describe Below)

**4.Tell us what happened and how it happened (Include as many details as possible FDA may reach out to you for any additional documents if necessary)**

I consumed 4 pieces from a fruity cereal chocolate bar from Diamond Shrumz. After a few hours, I fell unconscious and was found by my family barely responsive. I was taken to the ER and treated for a mushroom overdose with complication. I presented with tachycardia, generalized myoclonus, and an altered mental state. I was given a benzodiazepine and fluids and was discharged the same day.	
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**Relevant Test/Laboratory Data**

1 of 1

Test Name		Test Date	
Test Result		Test Unit	
Low Test Range		High Test Range	
More Information Available?			

## Additional Comments

I had a head CT, drug screen panel, cbc, metabolic panel, and UA and had no abnormal results.

## Section B - Product Availability

Do you still have the product in case we need to evaluate it?	No
Do you have a picture of the product? (check yes if you are including a picture)	No

## Section C - About the Products

1 of 1

Suspect	Yes		
Primary?	Yes		
Type	Drug/Biologic		
This report is about	Food/Medical food		
Name of the product as it appears on the box, bottle, or package (Include as many names as you see)	Fruity Cereal		
Name of the company that makes (or compounds) the product	Diamond Shrumz		
Product Type(check all that apply)	<input type="checkbox"/> Over-the-Counter <input type="checkbox"/> Compounded by a Pharmacy or an Outsourcing Facility <input type="checkbox"/> Generic <input type="checkbox"/> Biosimilar		
Strength		If Other	
NDC number			
Did the problem stop after the person reduced the dose or stopped taking or using the product?	Yes		
Did the problem return if the person started taking or using the product again?	Doesn't Apply		

## Drug Therapy

1 of 1

Expiration date			
Lot number			
Dosage Form			
Quantity		If Other	
Frequency		If Other	
How was it taken or used		If Other	
Date the person first started taking or using the product	20-May-2024		
Date the person stopped taking or using the product	20-May-2024		
Date the person reduced dose of the product			

Give best estimate of duration	
Is therapy still on-going?	
Why was the person using the product? (such as what condition was it supposed to treat) <span style="float: right;">1 of 1</span>	
Try microdosing to boost mood	
Returned to Manufacturer On	

**Section D - About the Medical Device**

Name of medical device	
Name of the company that makes the medical device	

Other identifying information (The model, catalog, lot, serial, or UDI number, and the expiration date, if you can locate them)

Model Number	
Catalog Number	
Lot Number	
Serial Number	
UDDI Number	
Expiration date	
Was someone operating the medical device when the problem occurred?	

**For implanted medical devices ONLY (such as pacemakers, breast implants, etc.)**

Date the implant was put in		Date the implant was taken out (If relevant)	
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**Section E - About the Person Who Had the Problem**

Person's Initials	(b) (6)
Sex	Female
Gender	Cisgender woman/girl
Please Specify Other Gender	
Age (specify unit of time for age)	25 Year(s)
Date of Birth	
Weight	85.5 kg
Ethnicity (Choose only one)	Not Hispanic/Latino
Race (Check all that apply)	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Asian <input checked="" type="checkbox"/> White <input type="checkbox"/> Black or African American

## List known medical conditions (Such as diabetes, high blood pressure, cancer, heart disease, or others)

Anxiety/depression

## Please list all allergies (such as to drugs, foods, pollen or others)

Pollen; ragweed; pet dander; mold

## List any other important information about the person (such as smoking, pregnancy, alcohol use, etc.)

Occasionally uses thc

## List all current prescription medications and medical devices being used.

Venlafaxine; buspar

## List all over-the-counter medications and any vitamins, minerals, supplements, and herbal remedies being used.

## Section F - About the Person Filling Out This Form

1 of 1

Primary?	Yes
Reporter is Patient?	
Title	
Last name	(b) (6)
Middle Name	
First name	(b) (6)
Number/Street	(b) (6)
City	(b) (6)
State/Province	(b) (6)
Country	UNITED STATES
ZIP or Postal code	(b) (6)
Telephone number	
Email address	(b) (6)
Fax	
Reporter Organization	

Department	
Reporter Speciality	
Today's date	11-Jun-2024
Did you report this problem to the company that makes the product (the manufacturer/compounder)?	No
If you do NOT want your identity disclosed to the manufacturer, please mark this box (Confidentiality Requested):	No

All dates displayed in the report are in EST(GMT-05:00) time zone

**Basic Details**

Company Unit	CDER-CTU	Originating Account	FAERS
Source Medium	MWO (Drug)	Source Form Type	E2B XML 3500B
Priority	Routine		
Override Auto Calculation Rule	No		
FDA Received Date	11-Jun-2024	CTU Received Date	11-Jun-2024
CTU Triage Date		CTU Data Entry Date	
Report Type	Spontaneous	Report Classification	Drug
Assign To	User		
User/Group			
Forward to Department	<input checked="" type="checkbox"/>		
Case Priority	Direct		

**Contact**

Case Reporter	First Name	Last Name	Email Address	Phone
<input checked="" type="checkbox"/>	(b) (6)	(b) (6)	(b) (6)	(b) (6)

**Section A - About the Problem**

What kind of problem was it? (Check all that apply)	<input checked="" type="checkbox"/> Were hurt or had a bad side effect (including new or worsening symptoms) <input type="checkbox"/> Used a product incorrectly which could have or led to a problem <input type="checkbox"/> Noticed a problem with the quality of the product <input type="checkbox"/> Had problems after switching from one product maker to another maker
Date the problem occurred	08-Jun-2024
Serious	Yes
Did any of the following happen? (Check all that apply)	<input checked="" type="checkbox"/> Hospitalization - admitted or stayed longer <input checked="" type="checkbox"/> Required help to prevent permanent harm <input type="checkbox"/> Disability or health problem <input type="checkbox"/> Birth defect <input type="checkbox"/> Life-threatening <input type="checkbox"/> Death <input checked="" type="checkbox"/> Other serious/important medical incident(Please Describe Below)
Other serious/important medical incident(Please Describe Below)	

4. Tell us what happened and how it happened (Include as many details as possible FDA may reach out to you for any additional documents if necessary)

On 6/8/2024, my husband ate Diamond Shrumz chocolate and had horrible effects. We were at an arena in (b) (6) and the negative side effects began about an hour after ingestion. It began with him crying saying that our family was dying. He then started running and fell down a flight of stairs. He got brought to the back of the arena by security and police officers. There, they checked his blood pressure and it was very high. He was on the floor screaming at the top of his lungs until an ambulance arrived. He was taken to (b) (6) hospital for 8 hours until the effects wore off. I was not allowed to see or speak to him the entire time he was in the hospital. He has no recollection of anything that happened. The police officers questioned me as my husband was unable to speak. They asked if he had drank any alcohol (which he had only drank water) and if he had taken any drugs (the only thing he had was the Golden Shrumz chocolate.) The officers said this product needs to be investigated as this should NOT have happened. In the past, he had eaten similar products and had NO effects like this, only a relaxation feeling. This was a life changing and traumatic experience for us both and this product should truly be taken off the market before it gets someone killed.
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**Relevant Test/Laboratory Data**

1 of 1

Test Name		Test Date	
Test Result		Test Unit	
Low Test Range		High Test Range	
More Information Available?			

### Additional Comments

(This section is optional)

### Section B - Product Availability

Do you still have the product in case we need to evaluate it?	No
Do you have a picture of the product? (check yes if you are including a picture)	No

### Section C - About the Products

1 of 1

Suspect	Yes		
Primary?	Yes		
Type	Drug/Biologic		
This report is about	Food/Medical food		
Name of the product as it appears on the box, bottle, or package (Include as many names as you see)	Golden Shrumz Premium Microdose Chocolate[INVAL ID]s and Cream		
Name of the company that makes (or compounds) the product			
Product Type(check all that apply)	<input checked="" type="checkbox"/> Over-the-Counter <input type="checkbox"/> Compounded by a Pharmacy or an Outsourcing Facility <input type="checkbox"/> Generic <input type="checkbox"/> Biosimilar		
Strength		If Other	
NDC number			
Did the problem stop after the person reduced the dose or stopped taking or using the product?	Yes		
Did the problem return if the person started taking or using the product again?	Doesn't Apply		

### Drug Therapy

1 of 1

Expiration date		
Lot number		
Dosage Form		
Quantity		If Other
Frequency		If Other

How was it taken or used		If Other	
Date the person first started taking or using the product	08-Jun-2024		
Date the person stopped taking or using the product	08-Jun-2024		
Date the person reduced dose of the product			
Give best estimate of duration			
Is therapy still on-going?			

Why was the person using the product? (such as what condition was it supposed to treat)

1 of 1

Ate the chocolate to feel relaxed

Returned to Manufacturer On

## Section D - About the Medical Device

Name of medical device	
Name of the company that makes the medical device	

Other identifying information (The model, catalog, lot, serial, or UDI number, and the expiration date, if you can locate them)

Model Number	
Catalog Number	
Lot Number	
Serial Number	
UDI Number	
Expiration date	
Was someone operating the medical device when the problem occurred?	

For implanted medical devices ONLY (such as pacemakers, breast implants, etc.)

Date the implant was put in	Date the implant was taken out (If relevant)
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## Section E - About the Person Who Had the Problem

Person's Initials	(b) (6)
Sex	Male
Gender	Cisgender man/boy
Please Specify Other Gender	
Age (specify unit of time for age)	28 Year(s)
Date of Birth	
Weight	90 kg

Ethnicity (Choose only one)	Not Hispanic/Latino
Race (Check all that apply)	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Asian <input checked="" type="checkbox"/> White <input type="checkbox"/> Black or African American

List known medical conditions (Such as diabetes, high blood pressure, cancer, heart disease, or others)

None
------

Please list all allergies (such as to drugs, foods, pollen or others)

None
------

List any other important information about the person (such as smoking, pregnancy, alcohol use, etc.)

No usage of drugs, alcohol, or nicotine
---

List all current prescription medications and medical devices being used.

None
------

List all over-the-counter medications and any vitamins, minerals, supplements, and herbal remedies being used.

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Section F - About the Person Filling Out This Form

1 of 1

Primary?	Yes
Reporter is Patient?	
Title	
Last name	(b) (6)
Middle Name	
First name	(b) (6)
Number/Street	
City	
State/Province	(b) (6)
Country	UNITED STATES

ZIP or Postal code	
Telephone number	(b) (6)
Email address	(b) (6)
Fax	
Reporter Organization	
Department	
Reporter Speciality	
Today's date	11-Jun-2024
Did you report this problem to the company that makes the product (the manufacturer/compounder)?	No
If you do NOT want your identity disclosed to the manufacturer, please mark this box (Confidentiality Requested):	Yes

All dates displayed in the report are in EST(GMT-05:00) time zone

**Basic Details**

Company Unit	CDER-CTU	Originating Account	FAERS
Source Medium	MWO (Drug)	Source Form Type	E2B XML 3500
Priority	Routine		
Override Auto Calculation Rule	No		
FDA Received Date	12-Jun-2024	CTU Received Date	12-Jun-2024
CTU Triage Date		CTU Data Entry Date	
Report Type	Spontaneous	Report Classification	Drug
Assign To	User		
User/Group			
Forward to Department	<input checked="" type="checkbox"/>		
Case Priority	Direct		

**Contact**

Case Reporter	First Name	Last Name	Email Address	Phone
<input checked="" type="checkbox"/>	(b) (6)	(b) (6)	(b) (6)	(b) (6)

**A. PATIENT INFORMATION**

Patient Identifier (In Confidence)	Unspecified
Age	
Date of Birth	(b) (6)
Sex	Male
Gender	Cisgender man/boy
Please Specify Other Gender	
Weight	
Ethnicity (Check single best answer)	Not Hispanic/Latino
Race (Check all that apply)	<input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> White <input type="checkbox"/> Native Hawaiian or Other Pacific Islander

**B. ADVERSE EVENT, PRODUCT PROBLEM**

Type of Report (check all that apply)	<input checked="" type="checkbox"/> Adverse Event <input type="checkbox"/> Product Use/Medication Error <input type="checkbox"/> Product Problem (e.g., defects/malfunctions) <input type="checkbox"/> Problem with Different Manufacturer of Same Medicine
Serious	Yes
Outcome Attributed to Adverse Event (Check all that apply)	<input type="checkbox"/> Death <input type="checkbox"/> Life Threatening <input checked="" type="checkbox"/> Hospitalization (initial or prolonged) <input type="checkbox"/> Other Serious or Important Medical Events <input type="checkbox"/> Disability or Permanent Damage

- |                          |  |
|--------------------------|--|
| <input type="checkbox"/> | Congenital Anomaly/Birth Defects                             |
| <input type="checkbox"/> | Required Intervention to Prevent Permanent Impairment/Damage |

Date of Death	
Date of Event	19-Apr-2024
Date of this Report	12-Jun-2024

**Describe Event, Problem or Product Use Error**

Describe Event, Problem, or Product Use Error: Patient was found unresponsive with an empty box of Diamond Shrumz Microdose Chocolate next to him. He was brought to the ED where he was found to have tachycardia and hypertension, and was responsive to painful stimuli only. He was given naloxone 0.4mg IV without any effect. At some point in the first 6 hours after ED presentation, he had a single seizure, which was treated with diazepam, midazolam, and intubation. He was sedated with a propofol drip. He was able to be extubated within 8 hours (hospital day 2) and was discharged in good condition two days later.

**Relevant Test/Laboratory Data**

1 of 1

Test Name		Test Date	
Test Result		Test Unit	
Low Test Range		High Test Range	
More Information Available?			

**Additional Comments**

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**Other Relevant History, Including Preexisting Medical Conditions**

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**C. PRODUCT AVAILABILITY**

Product Available for Evaluation? (Do not send product to FDA)	No
Returned to Manufacturer on	
Do you have a picture of the product? (check yes if you are including a picture)	No

**D. PRODUCT(S)**

1 of 1

Suspect	Yes	
Primary?	Yes	
Type	Drug/Biologic	
This report involves:	Other	

**Name, Strength, Manufacturer/Compounder (from product label)**

Product Name	Diamond Shrumz Microdose Chocolate	
Strength		If Other
Manufacturer/Compounder		

NDC# or Unique ID	
Product Type(check all that apply)	<input type="checkbox"/> OTC <input type="checkbox"/> Compounded <input type="checkbox"/> Generic <input type="checkbox"/> Biosimilar

Event Abated After Use Stopped or Dose Reduced?	Doesn't Apply
---	---------------

Event Reappeared after Reintroduction ?	Doesn't Apply
---	---------------

### Drug Therapy 1 of 1

Dose or Amount		If Other
Frequency		If Other
Route		If Other
Dosage Form		
Start		
Stop		
Dose Reduced		
Therapy Duration		If Other
Is therapy still on-going?		
Lot Number		
Expiration Date		

### Diagnosis for Use (indication) 1 of 1

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### E. SUSPECT MEDICAL DEVICE

Brand Name	
Common Device Name	
Procode	
Manufacturer Name	
City	
State	
Model #	
Lot #	
Catalog #	
Expiration Date	
Serial #	
Unique Identifier (UDI) #	
Operator of Device	<input type="checkbox"/> Health Professional <input type="checkbox"/> Patient/Consumer <input type="checkbox"/> Other
Other	
If Implanted, Give Date	

If Explanted, Give Date	
Is this a single-use device that was reprocessed and reused on a patient?	
If Yes for the above field, Enter Name and Address of Reprocessor	
Was this device serviced by a third party?	

**F. OTHER (CONCOMITANT) MEDICAL PRODUCTS****CONCOMITANT MEDICAL PRODUCT DESCRIPTION**

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**G. REPORTER**

1 of 1

Primary?	Yes		
Reporter is Patient?			
Title			
Last Name	(b) (6)		
Middle Name			
First Name	(b) (6)		
Address	(b) (6)		
City	(b) (6)		
State/Province/Region	(b) (6)		
Country	UNITED STATES	If Other	
ZIP/Postal Code	(b) (6)		
Phone	(b) (6)		
Email	(b) (6)		
Fax			
Reporter Organization			
Department			
Reporter Speciality			
Health Professional?	Yes		
Occupation	Pharmacist	If Other	
Also Reported to	<input type="checkbox"/> Manufacturer/Compounder <input type="checkbox"/> User Facility <input type="checkbox"/> Distributor/Importer		
If you do NOT want your identity disclosed to the manufacturer	Yes		

All dates displayed in the report are in EST(GMT-05:00) time zone

**Basic Details**

Company Unit	CDER-CTU	Originating Account	FAERS
Source Medium	MWO (Drug)	Source Form Type	E2B XML 3500
Priority	Routine		
Override Auto Calculation Rule	No		
FDA Received Date	12-Jun-2024	CTU Received Date	12-Jun-2024
CTU Triage Date		CTU Data Entry Date	
Report Type	Spontaneous	Report Classification	Drug
Assign To	User		
User/Group			
Forward to Department	<input checked="" type="checkbox"/>		
Case Priority	Direct		

**Contact**

Case Reporter	First Name	Last Name	Email Address	Phone
<input checked="" type="checkbox"/>	(b) (6)	(b) (6)	(b) (6)	(b) (6)

**A. PATIENT INFORMATION**

Patient Identifier (In Confidence)	Unspecified
Age	30 Year(s)
Date of Birth	
Sex	Male
Gender	Cisgender man/boy
Please Specify Other Gender	
Weight	
Ethnicity (Check single best answer)	
Race (Check all that apply)	<input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian or Other Pacific Islander

**B. ADVERSE EVENT, PRODUCT PROBLEM**

Type of Report (check all that apply)	<input checked="" type="checkbox"/> Adverse Event <input type="checkbox"/> Product Use/Medication Error <input type="checkbox"/> Product Problem (e.g., defects/malfunctions) <input type="checkbox"/> Problem with Different Manufacturer of Same Medicine
Serious	Yes
Outcome Attributed to Adverse Event (Check all that apply)	<input type="checkbox"/> Death <input type="checkbox"/> Life Threatening <input type="checkbox"/> Hospitalization (initial or prolonged) <input checked="" type="checkbox"/> Other Serious or Important Medical Events <input type="checkbox"/> Disability or Permanent Damage

- |                          |  |
|--------------------------|--|
| <input type="checkbox"/> | Congenital Anomaly/Birth Defects                             |
| <input type="checkbox"/> | Required Intervention to Prevent Permanent Impairment/Damage |

Date of Death	
Date of Event	08-Jun-2024
Date of this Report	12-Jun-2024

**Describe Event, Problem or Product Use Error**

Describe Event, Problem, or Product Use Error: Patient ate 3 pieces (out of 15 total) of a Diamond Shrumz chocolate bar. He had immediate vomiting, but no other issues or symptoms and did not seek medical attention. He called the poison center 2 days after ingestion to report his experience.

**Relevant Test/Laboratory Data**

1 of 1

Test Name		Test Date	
Test Result		Test Unit	
Low Test Range		High Test Range	
More Information Available?			

**Additional Comments**

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**Other Relevant History, Including Preexisting Medical Conditions**

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**C. PRODUCT AVAILABILITY**

Product Available for Evaluation? (Do not send product to FDA)	No
Returned to Manufacturer on	
Do you have a picture of the product? (check yes if you are including a picture)	No

**D. PRODUCT(S)**

1 of 1

Suspect	Yes	
Primary?	Yes	
Type	Drug/Biologic	
This report involves:	Other	

**Name, Strength, Manufacturer/Compounder (from product label)**

Product Name	Diamond Shrumz chocolate bar	
Strength		If Other
Manufacturer/Compounder		
NDC# or Unique ID		

	Product Type(check all that apply)	<input type="checkbox"/> OTC <input type="checkbox"/> Compounded <input type="checkbox"/> Generic <input type="checkbox"/> Biosimilar	
--	------------------------------------	--	--

	Event Abated After Use Stopped or Dose Reduced?	Yes	
--	---	-----	--

	Event Reappeared after Reintroduction ?	Doesn't Apply	
--	---	---------------	--

### Drug Therapy

1 of 1

Dose or Amount		If Other	
Frequency		If Other	
Route		If Other	
Dosage Form			
Start			
Stop			
Dose Reduced			
Therapy Duration		If Other	
Is therapy still on-going?			
Lot Number			
Expiration Date			

### Diagnosis for Use (indication)

1 of 1

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### E. SUSPECT MEDICAL DEVICE

Brand Name		
Common Device Name		
Procode		
Manufacturer Name		
City		
State		
Model #		
Lot #		
Catalog #		
Expiration Date		
Serial #		
Unique Identifier (UDI) #		
Operator of Device	<input type="checkbox"/> Health Professional <input type="checkbox"/> Patient/Consumer <input type="checkbox"/> Other	
Other		
If Implanted, Give Date		
If Explanted, Give Date		

Is this a single-use device that was reprocessed and reused on a patient?	
If Yes for the above field, Enter Name and Address of Reprocessor	
Was this device serviced by a third party?	

**F. OTHER (CONCOMITANT) MEDICAL PRODUCTS****CONCOMITANT MEDICAL PRODUCT DESCRIPTION**

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**G. REPORTER**

1 of 1

Primary?	Yes	
Reporter is Patient?		
Title		
Last Name	(b) (6)	
Middle Name		
First Name	(b) (6)	
Address	(b) (6)	
City	(b) (6)	
State/Province/Region	(b) (6)	
Country	UNITED STATES	If Other
ZIP/Postal Code	(b) (6)	
Phone	(b) (6)	
Email	(b) (6)	
Fax		
Reporter Organization		
Department		
Reporter Speciality		
Health Professional?	Yes	
Occupation	Pharmacist	If Other
Also Reported to	<input type="checkbox"/> Manufacturer/Compounder <input type="checkbox"/> User Facility <input type="checkbox"/> Distributor/Importer	
If you do NOT want your identity disclosed to the manufacturer	Yes	

All dates displayed in the report are in EST(GMT-05:00) time zone

**Basic Details**

Company Unit	CDER-CTU	Originating Account	FAERS
Source Medium	MWO (Drug)	Source Form Type	E2B XML 3500B
Priority	Routine		
Override Auto Calculation Rule	No		
FDA Received Date	12-Jun-2024	CTU Received Date	12-Jun-2024
CTU Triage Date		CTU Data Entry Date	
Report Type	Spontaneous	Report Classification	Drug
Assign To	User		
User/Group			
Forward to Department	<input checked="" type="checkbox"/>		
Case Priority	Direct		

**Contact**

Case Reporter	First Name	Last Name	Email Address	Phone
<input checked="" type="checkbox"/>	(b) (6)	(b) (6)	(b) (6)	(b) (6)

**Section A - About the Problem**

What kind of problem was it? (Check all that apply)	<input checked="" type="checkbox"/> Were hurt or had a bad side effect (including new or worsening symptoms) <input type="checkbox"/> Used a product incorrectly which could have or led to a problem <input type="checkbox"/> Noticed a problem with the quality of the product <input type="checkbox"/> Had problems after switching from one product maker to another maker
Date the problem occurred	09-Jan-2024
Serious	Yes
Did any of the following happen? (Check all that apply)	<input checked="" type="checkbox"/> Hospitalization - admitted or stayed longer <input type="checkbox"/> Required help to prevent permanent harm <input type="checkbox"/> Disability or health problem <input type="checkbox"/> Birth defect <input type="checkbox"/> Life-threatening <input type="checkbox"/> Death <input checked="" type="checkbox"/> Other serious/important medical incident(Please Describe Below)
Other serious/important medical incident(Please Describe Below)	

4. Tell us what happened and how it happened (Include as many details as possible FDA may reach out to you for any additional documents if necessary)

Event occurred between 01/08/2024-01/11/2024 Product name: SHRUUMZ I took 2 small squares, a tiny amount of this product - and I was in the hospital an hour later. The gas station clerk who sold it to me assured me the product held the same effect as CBD, so I purchased it not knowing any better. I waited in the hospital for hours in the waiting room until I regained partial consciousness. The ER clerk said there wasn't much they could do and had me wait in the lobby. This product did not just make me loose partial consciousness, there was a mask over my central nervous system. I had no ability to function properly. It gave me a pinhole-like vision and I didn't fully regain awareness/consciousness for almost 48 hours. During the event I could not interact with others properly (could not speak, didnt know what i was saying) i had very little awareness about what was going on around me, I could not speak for myself. This is a dangerous product. Please email or call me if you need more information.
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**Relevant Test/Laboratory Data**

1 of 1

Test Name		Test Date		
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Test Result		Test Unit	
Low Test Range		High Test Range	
More Information Available?			

**Additional Comments**

Unfortunately the hospital had me sit in the waiting room for hours and no one performed a blood or urine test.
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**Section B - Product Availability**

Do you still have the product in case we need to evaluate it?	No
Do you have a picture of the product? (check yes if you are including a picture)	Yes

**Section C - About the Products**

1 of 1

Suspect	Yes
Primary?	Yes
Type	Drug/Biologic
This report is about	Food/Medical food
Name of the product as it appears on the box, bottle, or package (Include as many names as you see)	Diamond Shruumz
Name of the company that makes (or compounds) the product	Diamond Shruumz(?)
Product Type(check all that apply)	<input type="checkbox"/> Over-the-Counter <input type="checkbox"/> Compounded by a Pharmacy or an Outsourcing Facility <input type="checkbox"/> Generic <input type="checkbox"/> Biosimilar
Strength	<input type="text"/> If Other
NDC number	
Did the problem stop after the person reduced the dose or stopped taking or using the product?	No
Did the problem return if the person started taking or using the product again?	Doesn't Apply

**Drug Therapy**

1 of 1

Expiration date			
Lot number			
Dosage Form			
Quantity		If Other	
Frequency	Other	If Other	2 tiny squares
How was it taken or used	Oral	If Other	

	Date the person first started taking or using the product	
	Date the person stopped taking or using the product	
	Date the person reduced dose of the product	
	Give best estimate of duration	1 Minute
	Is therapy still on-going?	
Why was the person using the product? (such as what condition was it supposed to treat)		1 of 1
	Was pressured by gas station clerk	

	Returned to Manufacturer On	
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#### Section D - About the Medical Device

Name of medical device	
Name of the company that makes the medical device	

Other identifying information (The model, catalog, lot, serial, or UDI number, and the expiration date, if you can locate them)

Model Number	
Catalog Number	
Lot Number	
Serial Number	
UDI Number	
Expiration date	
Was someone operating the medical device when the problem occurred?	

#### For implanted medical devices ONLY (such as pacemakers, breast implants, etc.)

Date the implant was put in		Date the implant was taken out (If relevant)	
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#### Section E - About the Person Who Had the Problem

Person's Initials	(b) (6)
Sex	Female
Gender	Cisgender woman/girl
Please Specify Other Gender	
Age (specify unit of time for age)	
Date of Birth	(b) (6)
Weight	109.35 kg
Ethnicity (Choose only one)	Not Hispanic/Latino

	Race (Check all that apply)	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black or African American	
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## List known medical conditions (Such as diabetes, high blood pressure, cancer, heart disease, or others)

	N/A none	
--	----------	--

## Please list all allergies (such as to drugs, foods, pollen or others)

	N/A none	
--	----------	--

## List any other important information about the person (such as smoking, pregnancy, alcohol use, etc.)

	N/A none	
--	----------	--

## List all current prescription medications and medical devices being used.

	None	
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## List all over-the-counter medications and any vitamins, minerals, supplements, and herbal remedies being used.

	None	
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## Section F - About the Person Filling Out This Form

1 of 1

Primary?	Yes
Reporter is Patient?	
Title	
Last name	(b) (6)
Middle Name	
First name	(b) (6)
Number/Street	(b) (6)
City	(b) (6)
State/Province	(b) (6)
Country	UNITED STATES
ZIP or Postal code	(b) (6)

Telephone number	(b) (6)
Email address	(b) (6)
Fax	
Reporter Organization	
Department	
Reporter Speciality	
Today's date	12-Jun-2024
Did you report this problem to the company that makes the product (the manufacturer/compounder)?	No
If you do NOT want your identity disclosed to the manufacturer, please mark this box (Confidentiality Requested):	No

## ⚠️ WARNING & DISCLAIMER ⚠️

- Do not drive vehicles or operate heavy machinery after consuming this product.
- Intoxicating effects of this product may be delayed.
- Warning: if consumed, may cause drowsiness.
- Warning: if consumed, may cause hallucinations.
- Consult a doctor before consuming this product.
- Do not use this product if you are pregnant or nursing.
- 21 and over only!
- KEEP AWAY FROM CHILDREN AND PETS.

### THIS IS NOT AN FDA APPROVED PRODUCT

These statements have not been evaluated by the FDA. This product is not intended to diagnose, treat, cure, or prevent any disease.

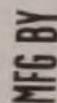
The purchaser of this product bears all risk and assumes all liability associated with the use, purchase, and possession of this product.

This product is intended only to be consumed in a legal and approved religious ceremony. Consumption outside of a legal ceremony may be a violation of the law. This product does not contain any scheduled substance and is not illegal to possess.

### INGREDIENTS

Cocoa mass, sugar, cocoa butter, milk, soy lecithin, unbleached enriched flour, canola oil, fructose syrup, corn starch, unsweetened chocolate, natural vanilla, sea salt, caffeine, mushroom nootropic, reishi mushroom, chaga mushroom and lions mane mushroom.

### CEREMONY INFORMATION



Prophet Premium Blends  
2413 S. Broadway  
Santa Ana, CA 92707



### VISIT OUR WEBSITE



All dates displayed in the report are in EST(GMT-05:00) time zone

**Basic Details**

Company Unit	CDER-CTU	Originating Account	FAERS
Source Medium	MWO (Drug)	Source Form Type	E2B XML 3500B
Priority	Routine		
Override Auto Calculation Rule	No		
FDA Received Date	12-Jun-2024	CTU Received Date	12-Jun-2024
CTU Triage Date		CTU Data Entry Date	
Report Type	Spontaneous	Report Classification	Drug
Assign To	User		
User/Group			
Forward to Department	<input checked="" type="checkbox"/>		
Case Priority	Direct		

**Contact**

Case Reporter	First Name	Last Name	Email Address	Phone
<input checked="" type="checkbox"/>	(b) (6)	(b) (6)	(b) (6)	(b) (6)

**Section A - About the Problem**

What kind of problem was it? (Check all that apply)	<input checked="" type="checkbox"/> Were hurt or had a bad side effect (including new or worsening symptoms) <input type="checkbox"/> Used a product incorrectly which could have or led to a problem <input type="checkbox"/> Noticed a problem with the quality of the product <input type="checkbox"/> Had problems after switching from one product maker to another maker
Date the problem occurred	22-Dec-2023
Serious	No
Did any of the following happen? (Check all that apply)	<input type="checkbox"/> Hospitalization - admitted or stayed longer <input type="checkbox"/> Required help to prevent permanent harm <input type="checkbox"/> Disability or health problem <input type="checkbox"/> Birth defect <input type="checkbox"/> Life-threatening <input type="checkbox"/> Death <input type="checkbox"/> Other serious/important medical incident(Please Describe Below)

4.Tell us what happened and how it happened (Include as many details as possible FDA may reach out to you for any additional documents if necessary)

Resting heart rate reached peak of 145 bpm while in a resting state, insomnia, nausea, cramps, and just felt very unwell for hours.	
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**Relevant Test/Laboratory Data**

1 of 1

Test Name		Test Date	
Test Result		Test Unit	
Low Test Range		High Test Range	
More Information Available?			

## Additional Comments

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## Section B - Product Availability

Do you still have the product in case we need to evaluate it?	No
Do you have a picture of the product? (check yes if you are including a picture)	Yes

## Section C - About the Products

1 of 1

Suspect	Yes		
Primary?	Yes		
Type	Drug/Biologic		
This report is about	Dietary Supplement		
Name of the product as it appears on the box, bottle, or package (Include as many names as you see)	watermelon wonderland		
Name of the company that makes (or compounds) the product	diamond shruumz		
Product Type(check all that apply)	<input checked="" type="checkbox"/> Over-the-Counter <input type="checkbox"/> Compounded by a Pharmacy or an Outsourcing Facility <input type="checkbox"/> Generic <input type="checkbox"/> Biosimilar		
Strength	500 mg milligram(s)	If Other	
NDC number			
Did the problem stop after the person reduced the dose or stopped taking or using the product?	Yes		
Did the problem return if the person started taking or using the product again?	Doesn't Apply		

## Drug Therapy

1 of 1

Expiration date			
Lot number			
Dosage Form			
Quantity	If Other		
Frequency	If Other		
How was it taken or used	Oral	If Other	
Date the person first started taking or using the product	22-Dec-2023		
Date the person stopped taking or using the product	22-Dec-2023		
Date the person reduced dose of the product			

Give best estimate of duration	
Is therapy still on-going?	
Why was the person using the product? (such as what condition was it supposed to treat)	
recreation	

1 of 1

Returned to Manufacturer On	
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Section D - About the Medical Device	
Name of medical device	
Name of the company that makes the medical device	

Other identifying information (The model, catalog, lot, serial, or UDI number, and the expiration date, if you can locate them)

Model Number	
Catalog Number	
Lot Number	
Serial Number	
UDI Number	
Expiration date	
Was someone operating the medical device when the problem occurred?	

For implanted medical devices ONLY (such as pacemakers, breast implants, etc.)		
Date the implant was put in		Date the implant was taken out (If relevant)

Section E - About the Person Who Had the Problem	
Person's Initials	(b) (6)
Sex	Female
Gender	Cisgender woman/girl
Please Specify Other Gender	
Age (specify unit of time for age)	34 Year(s)
Date of Birth	
Weight	55.35 kg
Ethnicity (Choose only one)	Not Hispanic/Latino
Race (Check all that apply)	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Asian <input checked="" type="checkbox"/> White <input type="checkbox"/> Black or African American

## List known medical conditions (Such as diabetes, high blood pressure, cancer, heart disease, or others)

None

## Please list all allergies (such as to drugs, foods, pollen or others)

Wheat, gluten (consumption doesn't cause extremely elevated resting heart rate spikes)

## List any other important information about the person (such as smoking, pregnancy, alcohol use, etc.)

Occasional drinks, less than CDC recommendations for females

## List all current prescription medications and medical devices being used.

None

## List all over-the-counter medications and any vitamins, minerals, supplements, and herbal remedies being used.

Ollie's melatonin gummies

## Section F - About the Person Filling Out This Form

1 of 1

Primary?	Yes
Reporter is Patient?	
Title	
Last name	(b) (6)
Middle Name	
First name	(b) (6)
Number/Street	
City	
State/Province	
Country	UNITED STATES
ZIP or Postal code	
Telephone number	(b) (6)
Email address	(b) (6)
Fax	
Reporter Organization	

Department	
Reporter Speciality	
Today's date	12-Jun-2024
Did you report this problem to the company that makes the product (the manufacturer/compounder)?	No
If you do NOT want your identity disclosed to the manufacturer, please mark this box (Confidentiality Requested):	Yes



diamondshruumz.com



2



DIAMOND™  
**SHRUUMZ**



# WATERMELON WONDERLAND — MEGA DOSE





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2



DIAMOND™  
**SHRUUMZ**



# WATERMELON WONDERLAND — MEGA DOSE



All dates displayed in the report are in EST(GMT-05:00) time zone

**Basic Details**

Company Unit	CDER-CTU	Originating Account	FAERS
Source Medium	MWO (Drug)	Source Form Type	E2B XML 3500B
Priority	Routine		
Override Auto Calculation Rule	No		
FDA Received Date	12-Jun-2024	CTU Received Date	12-Jun-2024
CTU Triage Date		CTU Data Entry Date	
Report Type	Spontaneous	Report Classification	Drug
Assign To	User		
User/Group			
Forward to Department	<input checked="" type="checkbox"/>		
Case Priority	Direct		

**Contact**

Case Reporter	First Name	Last Name	Email Address	Phone
<input checked="" type="checkbox"/>	(b) (6)	(b) (6)	(b) (6)	(b) (6)

**Section A - About the Problem**

What kind of problem was it? (Check all that apply)	<input checked="" type="checkbox"/> Were hurt or had a bad side effect (including new or worsening symptoms) <input type="checkbox"/> Used a product incorrectly which could have or led to a problem <input type="checkbox"/> Noticed a problem with the quality of the product <input type="checkbox"/> Had problems after switching from one product maker to another maker
Date the problem occurred	01-Jun-2024
Serious	No
Did any of the following happen? (Check all that apply)	<input type="checkbox"/> Hospitalization - admitted or stayed longer <input checked="" type="checkbox"/> Required help to prevent permanent harm <input type="checkbox"/> Disability or health problem <input type="checkbox"/> Birth defect <input type="checkbox"/> Life-threatening <input type="checkbox"/> Death <input type="checkbox"/> Other serious/important medical incident(Please Describe Below)

**4.Tell us what happened and how it happened (Include as many details as possible FDA may reach out to you for any additional documents if necessary)**

My partner and I took Diamond Shrumz birthday cake flavor. Within about 15 mins, I had severe GI cramps, nausea, and vomiting. Approx 15 minutes after that I had vertigo while walking and I fell. I was difficult to move bc my muscles were locked and they couldn't move my arms. I was not speaking clearly and was very sensitive to touch and things on my skin. My heart rate was relatively high and I was sweating. They were concerned I may have a seizure, but I did not. They observed me overnight and I was fine the next morning did not go to hospital or ED.	
---	--

**Relevant Test/Laboratory Data**

1 of 1

Test Name		Test Date	
Test Result		Test Unit	
Low Test Range		High Test Range	
More Information Available?			

## Additional Comments

--	--

## Section B - Product Availability

Do you still have the product in case we need to evaluate it?	No
Do you have a picture of the product? (check yes if you are including a picture)	No

## Section C - About the Products

1 of 1

Suspect	Yes		
Primary?	Yes		
Type	Drug/Biologic		
This report is about	Food/Medical food		
Name of the product as it appears on the box, bottle, or package (Include as many names as you see)	Shruums Birthday cake flavor		
Name of the company that makes (or compounds) the product	Diamond		
Product Type(check all that apply)	<input checked="" type="checkbox"/> Over-the-Counter <input type="checkbox"/> Compounded by a Pharmacy or an Outsourcing Facility <input type="checkbox"/> Generic <input type="checkbox"/> Biosimilar		
Strength		If Other	
NDC number			
Did the problem stop after the person reduced the dose or stopped taking or using the product?	Yes		
Did the problem return if the person started taking or using the product again?	Doesn't Apply		

## Drug Therapy

1 of 1

Expiration date			
Lot number			
Dosage Form			
Quantity		If Other	
Frequency		If Other	
How was it taken or used		If Other	
Date the person first started taking or using the product	01-Jun-2024		
Date the person stopped taking or using the product	01-Jun-2024		
Date the person reduced dose of the product			

Give best estimate of duration	
Is therapy still on-going?	
Why was the person using the product? (such as what condition was it supposed to treat)	
1 of 1	
Returned to Manufacturer On	

**Section D - About the Medical Device**

Name of medical device	
Name of the company that makes the medical device	

Other identifying information (The model, catalog, lot, serial, or UDI number, and the expiration date, if you can locate them)

Model Number	
Catalog Number	
Lot Number	
Serial Number	
UDI Number	
Expiration date	
Was someone operating the medical device when the problem occurred?	

**For implanted medical devices ONLY (such as pacemakers, breast implants, etc.)**

Date the implant was put in		Date the implant was taken out (If relevant)
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**Section E - About the Person Who Had the Problem**

Person's Initials	(b) (6)
Sex	Male
Gender	Cisgender man/boy
Please Specify Other Gender	
Age (specify unit of time for age)	
Date of Birth	(b) (6)
Weight	63 kg
Ethnicity (Choose only one)	Not Hispanic/Latino
Race (Check all that apply)	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Asian <input checked="" type="checkbox"/> White <input type="checkbox"/> Black or African American

## List known medical conditions (Such as diabetes, high blood pressure, cancer, heart disease, or others)

Hypertension, seasonal allergies, anxiety, ADHD, GERD, migraines,

## Please list all allergies (such as to drugs, foods, pollen or others)

None

## List any other important information about the person (such as smoking, pregnancy, alcohol use, etc.)

## List all current prescription medications and medical devices being used.

Ubrelvy 100mg prn migraine Bupropion xl 450mg once daily Atomoxetine 100mg once daily Methocarbamol 750mg prn muscle spasm Hydroxyzine Pamoate 50-75mg prn Paroxetine ER 37.5mg once daily Cetirizine 10mg once daily Famotidine 20 mg daily MVI daily Excedrine pen HA/migraine Ibuprofen 2-3 tabs prb pain Valsartan/HCTZ 80/12.5mg daily

## List all over-the-counter medications and any vitamins, minerals, supplements, and herbal remedies being used.

Magnesium glycinate Vitamin D3 Probiotics

## Section F - About the Person Filling Out This Form

1 of 1

Primary?	Yes
Reporter is Patient?	
Title	
Last name	(b) (6)
Middle Name	
First name	(b) (6)
Number/Street	(b) (6)
City	(b) (6)
State/Province	(b) (6)
Country	UNITED STATES
ZIP or Postal code	(b) (6)
Telephone number	(b) (6)
Email address	(b) (6)
Fax	
Reporter Organization	

Department	
Reporter Speciality	
Today's date	12-Jun-2024
Did you report this problem to the company that makes the product (the manufacturer/compounder)?	No
If you do NOT want your identity disclosed to the manufacturer, please mark this box (Confidentiality Requested):	No

All dates displayed in the report are in EST(GMT-05:00) time zone

### Basic Details

Company Unit	CDER-CTU	Originating Account	FAERS
Source Medium	MWO (Drug)	Source Form Type	E2B XML 3500B
Priority	Routine		
Override Auto Calculation Rule	No		
FDA Received Date	15-Jun-2024	CTU Received Date	15-Jun-2024
CTU Triage Date		CTU Data Entry Date	
Report Type	Spontaneous	Report Classification	Drug
Assign To	User		
User/Group			
Forward to Department	<input checked="" type="checkbox"/>		
Case Priority	Direct		

### Contact

Case Reporter	First Name	Last Name	Email Address	Phone
<input checked="" type="checkbox"/>	(b) (6)	(b) (6)	(b) (6)	

### Section A - About the Problem

What kind of problem was it? (Check all that apply)	<input checked="" type="checkbox"/> Were hurt or had a bad side effect (including new or worsening symptoms) <input type="checkbox"/> Used a product incorrectly which could have or led to a problem <input type="checkbox"/> Noticed a problem with the quality of the product <input type="checkbox"/> Had problems after switching from one product maker to another maker
Date the problem occurred	15-Jun-2024
Serious	Yes
Did any of the following happen? (Check all that apply)	<input type="checkbox"/> Hospitalization - admitted or stayed longer <input type="checkbox"/> Required help to prevent permanent harm <input type="checkbox"/> Disability or health problem <input type="checkbox"/> Birth defect <input type="checkbox"/> Life-threatening <input type="checkbox"/> Death <input checked="" type="checkbox"/> Other serious/important medical incident(Please Describe Below)
Other serious/important medical incident(Please Describe Below)	

4. Tell us what happened and how it happened (Include as many details as possible FDA may reach out to you for any additional documents if necessary)

Upon taking a medium recommended dose (6 pieces of Diamond Shrumz[INVALID]s and cream) and blacked out shortly afterward. I could not be woken by others and I vomited in my sleep. I awoke with a bitten tongue and blood on my pillowcase from it. I suspect I had a seizure. I was unable to seek medical care at this time, but the incident has not recurred upon cessation of product use.	
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### Relevant Test/Laboratory Data

1 of 1

Test Name		Test Date	
Test Result		Test Unit	
Low Test Range		High Test Range	

	More Information Available?	
<b>Additional Comments</b>		
<b>Section B - Product Availability</b>		
Do you still have the product in case we need to evaluate it?	No	
Do you have a picture of the product? (check yes if you are including a picture)	Yes	
<b>Section C - About the Products</b>		
1 of 1		
Suspect	Yes	
Primary?	Yes	
Type	Drug/Biologic	
This report is about	Food/Medical food	
Name of the product as it appears on the box, bottle, or package (Include as many names as you see)	Diamond Shrumz	
Name of the company that makes (or compounds) the product	Prophet Premium Blends	
Product Type(check all that apply)	<input checked="" type="checkbox"/> Over-the-Counter <input type="checkbox"/> Compounded by a Pharmacy or an Outsourcing Facility <input type="checkbox"/> Generic <input type="checkbox"/> Biosimilar	
Strength		If Other
NDC number		
Did the problem stop after the person reduced the dose or stopped taking or using the product?	Yes	
Did the problem return if the person started taking or using the product again?	Doesn't Apply	
<b>Drug Therapy</b>		
1 of 1		
Expiration date	30-Jun-2025	
Lot number		
Dosage Form		
Quantity	Other	If Other
Frequency	As needed	If Other
How was it taken or used	Oral	If Other
Date the person first started taking or using the product		
Date the person stopped taking or using the product		

Date the person reduced dose of the product	
Give best estimate of duration	1 Day
Is therapy still on-going?	
Why was the person using the product? (such as what condition was it supposed to treat)	
Recreational	

Returned to Manufacturer On	
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#### Section D - About the Medical Device

Name of medical device	
Name of the company that makes the medical device	

Other identifying information (The model, catalog, lot, serial, or UDI number, and the expiration date, if you can locate them)

Model Number	
Catalog Number	
Lot Number	
Serial Number	
UDI Number	
Expiration date	
Was someone operating the medical device when the problem occurred?	

#### For implanted medical devices ONLY (such as pacemakers, breast implants, etc.)

Date the implant was put in		Date the implant was taken out (If relevant)	
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#### Section E - About the Person Who Had the Problem

Person's Initials	Unspecified
Sex	Undifferentiated
Gender	Transgender man
Please Specify Other Gender	
Age (specify unit of time for age)	
Date of Birth	
Weight	67.5 kg
Ethnicity (Choose only one)	Not Hispanic/Latino
Race (Check all that apply)	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Asian

- |                          |                           |
|--------------------------|---------------------------|
| <input type="checkbox"/> | White                     |
| <input type="checkbox"/> | Black or African American |

## List known medical conditions (Such as diabetes, high blood pressure, cancer, heart disease, or others)

Autism, Ehlers Danlos Syndrome, ADHD, asthma

## Please list all allergies (such as to drugs, foods, pollen or others)

Prozac, naproxen, tree pollen

## List any other important information about the person (such as smoking, pregnancy, alcohol use, etc.)

Frequent cannabis use

## List all current prescription medications and medical devices being used.

Paroxetine, finasteride, testosterone

## List all over-the-counter medications and any vitamins, minerals, supplements, and herbal remedies being used.

## Section F - About the Person Filling Out This Form

1 of 1

Primary?	Yes
Reporter is Patient?	
Title	
Last name	(b) (6)
Middle Name	
First name	(b) (6)
Number/Street	
City	
State/Province	
Country	UNITED STATES
ZIP or Postal code	
Telephone number	
Email address	(b) (6)

Fax	
Reporter Organization	
Department	
Reporter Speciality	
Today's date	15-Jun-2024
Did you report this problem to the company that makes the product (the manufacturer/compounder)?	No
If you do NOT want your identity disclosed to the manufacturer, please mark this box (Confidentiality Requested):	Yes

LEADING FORM OF MICRODOSING

ENHANCED  
INGREDIENTS

DIA MOND™

SHROOMZ

PREMIUM MICRODOSE CHOCOLATE

WHITE CHOCOLATE WITH COOKIE BITS

COOKIES & CREAM

15 PIECE NET WEIGHT 1.6 OZ



## ⚠️ WARNINGS AND DISCLAIMERS

- Never attempt to operate any form of heavy machinery or moving vehicle while using this product.
- Intoxicating effects of this product may be delayed.
- Warning: if consumed, may cause drowsiness.
- Warning: if consumed, may cause spiritual experience.
- Consult a doctor before consuming this product.
- Do not use this product if you are pregnant or nursing.
- 21 and over only!
- KEEP AWAY FROM CHILDREN AND PETS.

### THIS IS NOT AN FDA APPROVED PRODUCT

These statements have not been evaluated by the FDA. This product is not intended to diagnose, treat, cure, or prevent any disease. The purchaser of this product bears all risk and assumes all liability associated with the use, purchase, and possession of this product.

## INGREDIENTS

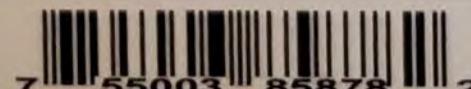
Cocoa Mass, Soy Lecithin, Sugar, Cocoa Butter, Milk, Corn Syrup, Cornstarch, Artificial Coloring, MCT Oil, Quantum Kava Liposome, Ashwagandha Extract, GABA, 5-HTP, Phosphatidylcholine, Caffeine Anhydrous, Muscimol, Lions Mane Mushroom Extract (Standardized to 30% Polysaccharides), Reishi Mushroom Extract, Chaga Mushroom Extract, and Rhodiola Rosea Extract.

DIAMONDSHROOMZ.COM



### DISTRIBUTED BY:

Prophet Premium Blends  
2413 S. Broadway  
Santa Ana, CA 92707



Batch: 0012  
Expiration Date: June, 2025

LAB TESTED



All dates displayed in the report are in EST(GMT-05:00) time zone

**Basic Details**

Company Unit	CDER-CTU	Originating Account	FAERS
Source Medium	MWO (Drug)	Source Form Type	E2B XML 3500B
Priority	Routine		
Override Auto Calculation Rule	No		
FDA Received Date	18-Jun-2024	CTU Received Date	18-Jun-2024
CTU Triage Date		CTU Data Entry Date	
Report Type	Spontaneous	Report Classification	Drug
Assign To	User		
User/Group			
Forward to Department	<input checked="" type="checkbox"/>		
Case Priority	Direct		

**Contact**

Case Reporter	First Name	Last Name	Email Address	Phone
<input checked="" type="checkbox"/>	Anonymous	Anonymous		

**Section A - About the Problem**

What kind of problem was it? (Check all that apply)	<input checked="" type="checkbox"/> Were hurt or had a bad side effect (including new or worsening symptoms) <input type="checkbox"/> Used a product incorrectly which could have or led to a problem <input type="checkbox"/> Noticed a problem with the quality of the product <input type="checkbox"/> Had problems after switching from one product maker to another maker
Date the problem occurred	17-Jun-2024
Serious	Yes
Did any of the following happen? (Check all that apply)	<input type="checkbox"/> Hospitalization - admitted or stayed longer <input type="checkbox"/> Required help to prevent permanent harm <input type="checkbox"/> Disability or health problem <input type="checkbox"/> Birth defect <input type="checkbox"/> Life-threatening <input type="checkbox"/> Death <input checked="" type="checkbox"/> Other serious/important medical incident(Please Describe Below)
Other serious/important medical incident(Please Describe Below)	

4. Tell us what happened and how it happened (Include as many details as possible FDA may reach out to you for any additional documents if necessary)

On June 17, 2024 at 4:45 pm my husband and I ate one each of the Diamond Shrumz-Brand Chocolate Ice Cream Cone. My husband had mild reactions including: light euphoria on a level of 1 to 10, he said it was a 2. I however had a completely different experience, with side effects being severe nausea, room spinning, vomiting, diarrhea, profuse sweating, chills, fever, shakes and closed-eye hallucinations. The whole experience lasted approximately 12 hours with lingering side effects into the next day.	
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**Relevant Test/Laboratory Data**

1 of 1

Test Name		Test Date	
Test Result		Test Unit	
Low Test Range		High Test Range	

	More Information Available?	
<b>Additional Comments</b>		
<b>Section B - Product Availability</b>		
Do you still have the product in case we need to evaluate it?	No	
Do you have a picture of the product? (check yes if you are including a picture)	Yes	
<b>Section C - About the Products</b>		
1 of 1		
Suspect	Yes	
Primary?	Yes	
Type	Drug/Biologic	
This report is about	Other	
Name of the product as it appears on the box, bottle, or package (Include as many names as you see)	Diamond Shrumz Double Chocolate Chip Infused Cones	
Name of the company that makes (or compounds) the product	Diamond Shrumz, Prophet Premium B	
Product Type(check all that apply)	<input checked="" type="checkbox"/> Over-the-Counter <input type="checkbox"/> Compounded by a Pharmacy or an Outsourcing Facility <input type="checkbox"/> Generic <input type="checkbox"/> Biosimilar	
Strength	57 G gram(s)	If Other
NDC number	10133 32000	
Did the problem stop after the person reduced the dose or stopped taking or using the product?	No	
Did the problem return if the person started taking or using the product again?	Doesn't Apply	
<b>Drug Therapy</b>		
1 of 1		
Expiration date	01-Dec-2024	
Lot number	Batch 0002	
Dosage Form		
Quantity	Other	If Other
Frequency	Other	If Other
How was it taken or used	Oral	If Other
Date the person first started taking or using the product		
Date the person stopped taking or using the product		

Date the person reduced dose of the product	
Give best estimate of duration	12 Hour
Is therapy still on-going?	
Why was the person using the product? (such as what condition was it supposed to treat) <span style="float: right;">1 of 1</span>	
Sleep	

Returned to Manufacturer On	
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#### Section D - About the Medical Device

Name of medical device	
Name of the company that makes the medical device	

Other identifying information (The model, catalog, lot, serial, or UDI number, and the expiration date, if you can locate them)

Model Number	
Catalog Number	
Lot Number	
Serial Number	
UDI Number	
Expiration date	
Was someone operating the medical device when the problem occurred?	

#### For implanted medical devices ONLY (such as pacemakers, breast implants, etc.)

Date the implant was put in		Date the implant was taken out (If relevant)	
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#### Section E - About the Person Who Had the Problem

Person's Initials	(b) (6)
Sex	Female
Gender	Not selected
Please Specify Other Gender	
Age (specify unit of time for age)	46 Year(s)
Date of Birth	
Weight	85.5 kg
Ethnicity (Choose only one)	Not Hispanic/Latino
Race (Check all that apply)	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Asian

<input checked="" type="checkbox"/> White
<input type="checkbox"/> Black or African American

List known medical conditions (Such as diabetes, high blood pressure, cancer, heart disease, or others)

Please list all allergies (such as to drugs, foods, pollen or others)

List any other important information about the person (such as smoking, pregnancy, alcohol use, etc.)

List all current prescription medications and medical devices being used.

List all over-the-counter medications and any vitamins, minerals, supplements, and herbal remedies being used.

#### Section F - About the Person Filling Out This Form

1 of 1

Primary?	Yes
Reporter is Patient?	
Title	
Last name	Anonymous
Middle Name	
First name	Anonymous
Number/Street	
City	
State/Province	
Country	UNITED STATES
ZIP or Postal code	
Telephone number	
Email address	

Fax	
Reporter Organization	
Department	
Reporter Speciality	
Today's date	18-Jun-2024
Did you report this problem to the company that makes the product (the manufacturer/compounder)?	No
If you do NOT want your identity disclosed to the manufacturer, please mark this box (Confidentiality Requested):	Yes



All dates displayed in the report are in EST(GMT-05:00) time zone

**Basic Details**

Company Unit	CDER-CTU	Originating Account	FAERS
Source Medium	MWO (Drug)	Source Form Type	E2B XML 3500B
Priority	Routine		
Override Auto Calculation Rule	No		
FDA Received Date	18-Jun-2024	CTU Received Date	18-Jun-2024
CTU Triage Date		CTU Data Entry Date	
Report Type	Spontaneous	Report Classification	Drug
Assign To	User		
User/Group			
Forward to Department	<input checked="" type="checkbox"/>		
Case Priority	Direct		

**Contact**

Case Reporter	First Name	Last Name	Email Address	Phone
<input checked="" type="checkbox"/>	Anonymous	Anonymous		

**Section A - About the Problem**

What kind of problem was it? (Check all that apply)	<input checked="" type="checkbox"/> Were hurt or had a bad side effect (including new or worsening symptoms) <input type="checkbox"/> Used a product incorrectly which could have or led to a problem <input type="checkbox"/> Noticed a problem with the quality of the product <input type="checkbox"/> Had problems after switching from one product maker to another maker
Date the problem occurred	17-Jun-2024
Serious	Yes
Did any of the following happen? (Check all that apply)	<input type="checkbox"/> Hospitalization - admitted or stayed longer <input type="checkbox"/> Required help to prevent permanent harm <input type="checkbox"/> Disability or health problem <input type="checkbox"/> Birth defect <input type="checkbox"/> Life-threatening <input type="checkbox"/> Death <input checked="" type="checkbox"/> Other serious/important medical incident(Please Describe Below)
Other serious/important medical incident(Please Describe Below)	

4. Tell us what happened and how it happened (Include as many details as possible FDA may reach out to you for any additional documents if necessary)

On June 17, 2024 at 4:45 pm my husband and I ate one each of the Diamond Shrumz-Brand Chocolate Ice Cream Cone. My husband had mild reactions including: light euphoria on a level of 1 to 10, he said it was a 2. I however had a completely different experience, with side effects being severe nausea, room spinning, vomiting, diarrhea, profuse sweating, chills, fever, shakes and closed-eye hallucinations. The whole experience lasted approximately 12 hours with lingering side effects into the next day.	
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**Relevant Test/Laboratory Data**

1 of 1

Test Name		Test Date	
Test Result		Test Unit	
Low Test Range		High Test Range	

	More Information Available?	
<b>Additional Comments</b>		
<b>Section B - Product Availability</b>		
Do you still have the product in case we need to evaluate it?	No	
Do you have a picture of the product? (check yes if you are including a picture)	Yes	
<b>Section C - About the Products</b>		
1 of 1		
Suspect	Yes	
Primary?	Yes	
Type	Drug/Biologic	
This report is about	Other	
Name of the product as it appears on the box, bottle, or package (Include as many names as you see)	Diamond Shrumz Double Chocolate Chip Infused Cones	
Name of the company that makes (or compounds) the product	Diamond Shrumz, Prophet Premium B	
Product Type(check all that apply)	<input checked="" type="checkbox"/> Over-the-Counter <input type="checkbox"/> Compounded by a Pharmacy or an Outsourcing Facility <input type="checkbox"/> Generic <input type="checkbox"/> Biosimilar	
Strength	57 G gram(s)	If Other
NDC number	10133 32000	
Did the problem stop after the person reduced the dose or stopped taking or using the product?	No	
Did the problem return if the person started taking or using the product again?	Doesn't Apply	
<b>Drug Therapy</b>		
1 of 1		
Expiration date	01-Dec-2024	
Lot number	Batch 0002	
Dosage Form		
Quantity	Other	If Other
Frequency	Other	If Other
How was it taken or used	Oral	If Other
Date the person first started taking or using the product		
Date the person stopped taking or using the product		

Date the person reduced dose of the product	
Give best estimate of duration	12 Hour
Is therapy still on-going?	
Why was the person using the product? (such as what condition was it supposed to treat) <span style="float: right;">1 of 1</span>	
Sleep	

Returned to Manufacturer On	
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#### Section D - About the Medical Device

Name of medical device	
Name of the company that makes the medical device	

Other identifying information (The model, catalog, lot, serial, or UDI number, and the expiration date, if you can locate them)

Model Number	
Catalog Number	
Lot Number	
Serial Number	
UDI Number	
Expiration date	
Was someone operating the medical device when the problem occurred?	

#### For implanted medical devices ONLY (such as pacemakers, breast implants, etc.)

Date the implant was put in		Date the implant was taken out (If relevant)	
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#### Section E - About the Person Who Had the Problem

Person's Initials	(b) (6)
Sex	Female
Gender	Not selected
Please Specify Other Gender	
Age (specify unit of time for age)	46 Year(s)
Date of Birth	
Weight	85.5 kg
Ethnicity (Choose only one)	Not Hispanic/Latino
Race (Check all that apply)	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Asian

White Black or African American

List known medical conditions (Such as diabetes, high blood pressure, cancer, heart disease, or others)

Please list all allergies (such as to drugs, foods, pollen or others)

List any other important information about the person (such as smoking, pregnancy, alcohol use, etc.)

List all current prescription medications and medical devices being used.

List all over-the-counter medications and any vitamins, minerals, supplements, and herbal remedies being used.

## Section F - About the Person Filling Out This Form

1 of 1

Primary?	Yes
Reporter is Patient?	
Title	
Last name	Anonymous
Middle Name	
First name	Anonymous
Number/Street	
City	
State/Province	
Country	UNITED STATES
ZIP or Postal code	
Telephone number	
Email address	

Fax	
Reporter Organization	
Department	
Reporter Speciality	
Today's date	18-Jun-2024
Did you report this problem to the company that makes the product (the manufacturer/compounder)?	No
If you do NOT want your identity disclosed to the manufacturer, please mark this box (Confidentiality Requested):	Yes



All dates displayed in the report are in EST(GMT-05:00) time zone

**Basic Details**

Company Unit	CDER-CTU	Originating Account	FAERS
Source Medium	MWO (Drug)	Source Form Type	E2B XML 3500B
Priority	Routine		
Override Auto Calculation Rule	No		
FDA Received Date	21-Jun-2024	CTU Received Date	21-Jun-2024
CTU Triage Date		CTU Data Entry Date	
Report Type	Spontaneous	Report Classification	Drug
Assign To	User		
User/Group			
Forward to Department	<input checked="" type="checkbox"/>		
Case Priority	Direct		

**Contact**

Case Reporter	First Name	Last Name	Email Address	Phone
<input checked="" type="checkbox"/>	(b) (6)	(b) (6)	(b) (6)	(b) (6)

**Section A - About the Problem**

What kind of problem was it? (Check all that apply)	<input checked="" type="checkbox"/> Were hurt or had a bad side effect (including new or worsening symptoms) <input type="checkbox"/> Used a product incorrectly which could have or led to a problem <input type="checkbox"/> Noticed a problem with the quality of the product <input type="checkbox"/> Had problems after switching from one product maker to another maker
Date the problem occurred	18-Jun-2024
Serious	No
Did any of the following happen? (Check all that apply)	<input type="checkbox"/> Hospitalization - admitted or stayed longer <input type="checkbox"/> Required help to prevent permanent harm <input type="checkbox"/> Disability or health problem <input type="checkbox"/> Birth defect <input type="checkbox"/> Life-threatening <input type="checkbox"/> Death <input type="checkbox"/> Other serious/important medical incident(Please Describe Below)

4.Tell us what happened and how it happened (Include as many details as possible FDA may reach out to you for any additional documents if necessary)

Diamond Shrumz dark chocolate bar, of which 6/15 squares were ingested. Initial symptoms: Vomiting Diarrhea Complete dis-regulation of nervous system: muscle spasms, confusion, shallow breathing, loss of consciousness. No medical attention was sought after discussion with Poison Control. Lingering symptoms: Nausea Shakiness Anxiety Total loss of appetite Sleeplessness Lightheadedness Hypoglycemia Unused product returned to retailer.	
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**Relevant Test/Laboratory Data**

1 of 1

Test Name		Test Date	
Test Result		Test Unit	
Low Test Range		High Test Range	
More Information Available?			

## Additional Comments

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## Section B - Product Availability

Do you still have the product in case we need to evaluate it?	No
Do you have a picture of the product? (check yes if you are including a picture)	Yes

## Section C - About the Products

1 of 1

Suspect	Yes		
Primary?	Yes		
Type	Drug/Biologic		
This report is about	Food/Medical food		
Name of the product as it appears on the box, bottle, or package (Include as many names as you see)	Diamond Shrumz		
Name of the company that makes (or compounds) the product			
Product Type(check all that apply)	<input checked="" type="checkbox"/> Over-the-Counter <input type="checkbox"/> Compounded by a Pharmacy or an Outsourcing Facility <input type="checkbox"/> Generic <input type="checkbox"/> Biosimilar		
Strength		If Other	
NDC number			
Did the problem stop after the person reduced the dose or stopped taking or using the product?	Yes		
Did the problem return if the person started taking or using the product again?	Doesn't Apply		

## Drug Therapy

1 of 1

Expiration date			
Lot number			
Dosage Form			
Quantity		If Other	
Frequency		If Other	
How was it taken or used		If Other	
Date the person first started taking or using the product	18-Jun-2024		
Date the person stopped taking or using the product	18-Jun-2024		
Date the person reduced dose of the product			

Give best estimate of duration	
Is therapy still on-going?	
Why was the person using the product? (such as what condition was it supposed to treat) <span style="float: right;">1 of 1</span>	
Returned to Manufacturer On	

**Section D - About the Medical Device**

Name of medical device	
Name of the company that makes the medical device	

Other identifying information (The model, catalog, lot, serial, or UDI number, and the expiration date, if you can locate them)

Model Number	
Catalog Number	
Lot Number	
Serial Number	
UDI Number	
Expiration date	
Was someone operating the medical device when the problem occurred?	

**For implanted medical devices ONLY (such as pacemakers, breast implants, etc.)**

Date the implant was put in		Date the implant was taken out (If relevant)	
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**Section E - About the Person Who Had the Problem**

Person's Initials	(b) (6)
Sex	Female
Gender	Cisgender woman/girl
Please Specify Other Gender	
Age (specify unit of time for age)	55 Year(s)
Date of Birth	
Weight	62.1 kg
Ethnicity (Choose only one)	Not Hispanic/Latino
Race (Check all that apply)	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Asian <input checked="" type="checkbox"/> White <input type="checkbox"/> Black or African American

## List known medical conditions (Such as diabetes, high blood pressure, cancer, heart disease, or others)

N/A

## Please list all allergies (such as to drugs, foods, pollen or others)

N/A

## List any other important information about the person (such as smoking, pregnancy, alcohol use, etc.)

N/A

## List all current prescription medications and medical devices being used.

N/A

## List all over-the-counter medications and any vitamins, minerals, supplements, and herbal remedies being used.

N/A

## Section F - About the Person Filling Out This Form

1 of 1

Primary?	Yes
Reporter is Patient?	
Title	
Last name	(b) (6)
Middle Name	
First name	(b) (6)
Number/Street	(b) (6)
City	(b) (6)
State/Province	(b) (6)
Country	UNITED STATES
ZIP or Postal code	(b) (6)
Telephone number	(b) (6)
Email address	(b) (6)
Fax	
Reporter Organization	

Department	
Reporter Speciality	
Today's date	21-Jun-2024
Did you report this problem to the company that makes the product (the manufacturer/compounder)?	Yes
If you do NOT want your identity disclosed to the manufacturer, please mark this box (Confidentiality Requested):	No



All dates displayed in the report are in EST(GMT-05:00) time zone

**Basic Details**

Company Unit	CDER-CTU	Originating Account	FAERS
Source Medium	MWO (Drug)	Source Form Type	E2B XML 3500
Priority	Routine		
Override Auto Calculation Rule	No		
FDA Received Date	22-Jun-2024	CTU Received Date	22-Jun-2024
CTU Triage Date		CTU Data Entry Date	
Report Type	Spontaneous	Report Classification	Drug
Assign To	User		
User/Group			
Forward to Department	<input checked="" type="checkbox"/>		
Case Priority	Direct		

**Contact**

Case Reporter	First Name	Last Name	Email Address	Phone
<input checked="" type="checkbox"/>	(b) (6)	(b) (6)	(b) (6)	(b) (6)

**A. PATIENT INFORMATION**

Patient Identifier (In Confidence)	(b) (6)
Age	21 Year(s)
Date of Birth	
Sex	Male
Gender	Decline to answer
Please Specify Other Gender	
Weight	
Ethnicity (Check single best answer)	
Race (Check all that apply)	<input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian or Other Pacific Islander

**B. ADVERSE EVENT, PRODUCT PROBLEM**

Type of Report (check all that apply)	<input checked="" type="checkbox"/> Adverse Event <input type="checkbox"/> Product Use/Medication Error <input type="checkbox"/> Product Problem (e.g., defects/malfunctions) <input type="checkbox"/> Problem with Different Manufacturer of Same Medicine
Serious	Yes
Outcome Attributed to Adverse Event (Check all that apply)	<input type="checkbox"/> Death <input type="checkbox"/> Life Threatening <input checked="" type="checkbox"/> Hospitalization (initial or prolonged) <input type="checkbox"/> Other Serious or Important Medical Events <input type="checkbox"/> Disability or Permanent Damage

- |                          |  |
|--------------------------|--|
| <input type="checkbox"/> | Congenital Anomaly/Birth Defects                             |
| <input type="checkbox"/> | Required Intervention to Prevent Permanent Impairment/Damage |

Date of Death	
Date of Event	14-Jun-2024
Date of this Report	22-Jun-2024

**| Describe Event, Problem or Product Use Error**

Describe Event, Problem, or Product Use Error: Patient smoked weed and took 15 pieces of shruumz chocolate while out with friends. EMS was called because of agitation, combativeness, and AMS. He was hallucinating. He was intubated for airway protection.

**| Relevant Test/Laboratory Data**

1 of 1

Test Name		Test Date	
Test Result		Test Unit	
Low Test Range		High Test Range	
More Information Available?			

**| Additional Comments**

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**| Other Relevant History, Including Preexisting Medical Conditions**

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**| C. PRODUCT AVAILABILITY**

Product Available for Evaluation? (Do not send product to FDA)	No
Returned to Manufacturer on	
Do you have a picture of the product? (check yes if you are including a picture)	No

**| D. PRODUCT(S)**

1 of 1

Suspect	Yes	
Primary?	Yes	
Type	Drug/Biologic	
This report involves:	Food/Medical food	

**| Name, Strength, Manufacturer/Compounder (from product label)**

Product Name	Diamond Shrumz chocolate	
Strength		If Other
Manufacturer/Compounder		
NDC# or Unique ID		

	Product Type(check all that apply)	<input checked="" type="checkbox"/> OTC <input type="checkbox"/> Compounded <input type="checkbox"/> Generic <input type="checkbox"/> Biosimilar	
	Event Abated After Use Stopped or Dose Reduced?	Yes	
	Event Reappeared after Reintroduction ?	Doesn't Apply	

Drug Therapy		1 of 1	
Dose or Amount		If Other	
Frequency		If Other	
Route		If Other	
Dosage Form			
Start	14-Jun-2024		
Stop	14-Jun-2024		
Dose Reduced			
Therapy Duration		If Other	
Is therapy still on-going?	No		
Lot Number			
Expiration Date			

Diagnosis for Use (indication)		1 of 1	

E. SUSPECT MEDICAL DEVICE			
Brand Name			
Common Device Name			
Procode			
Manufacturer Name			
City			
State			
Model #			
Lot #			
Catalog #			
Expiration Date			
Serial #			
Unique Identifier (UDI) #			
Operator of Device	<input type="checkbox"/> Health Professional <input type="checkbox"/> Patient/Consumer <input type="checkbox"/> Other		
Other			
If Implanted, Give Date			
If Explanted, Give Date			

Is this a single-use device that was reprocessed and reused on a patient?	
If Yes for the above field, Enter Name and Address of Reprocessor	
Was this device serviced by a third party?	

**F. OTHER (CONCOMITANT) MEDICAL PRODUCTS****CONCOMITANT MEDICAL PRODUCT DESCRIPTION**

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**G. REPORTER**

1 of 1

Primary?	Yes	
Reporter is Patient?		
Title		
Last Name	(b) (6)	
Middle Name		
First Name	(b) (6)	
Address	(b) (6)	
City	(b) (6)	
State/Province/Region	(b) (6)	
Country	UNITED STATES	If Other
ZIP/Postal Code	(b) (6)	
Phone	(b) (6)	
Email	(b) (6)	
Fax		
Reporter Organization		
Department		
Reporter Speciality		
Health Professional?	Yes	
Occupation	Pharmacist	If Other
Also Reported to	<input type="checkbox"/> Manufacturer/Compounder <input type="checkbox"/> User Facility <input type="checkbox"/> Distributor/Importer	
If you do NOT want your identity disclosed to the manufacturer	Yes	

All dates displayed in the report are in EST(GMT-05:00) time zone

**Basic Details**

Company Unit	CDER-CTU	Originating Account	FAERS
Source Medium	MWO (Drug)	Source Form Type	E2B XML 3500B
Priority	Routine		
Override Auto Calculation Rule	No		
FDA Received Date	23-Jun-2024	CTU Received Date	23-Jun-2024
CTU Triage Date		CTU Data Entry Date	
Report Type	Spontaneous	Report Classification	Drug
Assign To	User		
User/Group			
Forward to Department	<input checked="" type="checkbox"/>		
Case Priority	Direct		

**Contact**

Case Reporter	First Name	Last Name	Email Address	Phone
<input checked="" type="checkbox"/>	(b) (6)	(b) (6)	(b) (6)	(b) (6)

**Section A - About the Problem**

What kind of problem was it? (Check all that apply)	<input checked="" type="checkbox"/> Were hurt or had a bad side effect (including new or worsening symptoms) <input type="checkbox"/> Used a product incorrectly which could have or led to a problem <input type="checkbox"/> Noticed a problem with the quality of the product <input type="checkbox"/> Had problems after switching from one product maker to another maker
Date the problem occurred	19-Apr-2024
Serious	Yes
Did any of the following happen? (Check all that apply)	<input checked="" type="checkbox"/> Hospitalization - admitted or stayed longer <input type="checkbox"/> Required help to prevent permanent harm <input type="checkbox"/> Disability or health problem <input type="checkbox"/> Birth defect <input type="checkbox"/> Life-threatening <input type="checkbox"/> Death <input type="checkbox"/> Other serious/important medical incident(Please Describe Below)

**4. Tell us what happened and how it happened (Include as many details as possible FDA may reach out to you for any additional documents if necessary)**

Went into a vape shop looking for supplements to help relax like lions mane or chaga. Found the diamond shrumpz chocolate bar and read the label, scanned the lab test qr and asked every question we could, no red flags, so me and my boyfriend took half a bar each. Approx. 30 minutes later we were both having seizures and having hallucinations (tripping). We were vomiting uncontrollably, and my boyfriend ended up being conscious enough at one point to call 911. Arrived at the ER at around 10:30 pm and was not released until 8 am the next morning. Low blood pressure, high heart rate, seizures, unconscious for approx. 30 minutes each bout. Didn't fully recover until about 5 days later.
--

**Relevant Test/Laboratory Data**

1 of 1

Test Name		Test Date	19-Apr-2024
Test Result		Test Unit	
Low Test Range		High Test Range	

	More Information Available?	
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### Additional Comments

	Not exactly what tests were done, but I know they did a full toxicity report and nothing came back.	
--	---	--

### Section B - Product Availability

Do you still have the product in case we need to evaluate it?	Yes	
Do you have a picture of the product? (check yes if you are including a picture)	Yes	

### Section C - About the Products 1 of 1

Suspect	Yes	
Primary?	Yes	
Type	Drug/Biologic	
This report is about	Dietary Supplement	
Name of the product as it appears on the box, bottle, or package (Include as many names as you see)	Diamond Shrumz	
Name of the company that makes (or compounds) the product	Prophet Premium Blends	
Product Type(check all that apply)	<input checked="" type="checkbox"/> Over-the-Counter <input type="checkbox"/> Compounded by a Pharmacy or an Outsourcing Facility <input type="checkbox"/> Generic <input type="checkbox"/> Biosimilar	
Strength		If Other
NDC number		
Did the problem stop after the person reduced the dose or stopped taking or using the product?	No	
Did the problem return if the person started taking or using the product again?	Doesn't Apply	

### Drug Therapy 1 of 1

Expiration date	01-Jul-2025	
Lot number	0011	
Dosage Form		
Quantity		If Other
Frequency		If Other
How was it taken or used	Oral	If Other
Date the person first started taking or using the product		
Date the person stopped taking or using the product		

Date the person reduced dose of the product	
Give best estimate of duration	10 Hour
Is therapy still on-going?	
Why was the person using the product? (such as what condition was it supposed to treat) <span style="float: right;">1 of 1</span>	
Relaxation	

Returned to Manufacturer On	
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#### Section D - About the Medical Device

Name of medical device	
Name of the company that makes the medical device	

Other identifying information (The model, catalog, lot, serial, or UDI number, and the expiration date, if you can locate them)

Model Number	
Catalog Number	
Lot Number	
Serial Number	
UDI Number	
Expiration date	
Was someone operating the medical device when the problem occurred?	

#### For implanted medical devices ONLY (such as pacemakers, breast implants, etc.)

Date the implant was put in		Date the implant was taken out (If relevant)	
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#### Section E - About the Person Who Had the Problem

Person's Initials	(b) (6)
Sex	Female
Gender	Cisgender woman/girl
Please Specify Other Gender	
Age (specify unit of time for age)	24 Year(s)
Date of Birth	
Weight	60.75 kg
Ethnicity (Choose only one)	Not Hispanic/Latino
Race (Check all that apply)	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Asian

<input checked="" type="checkbox"/> White
<input type="checkbox"/> Black or African American

List known medical conditions (Such as diabetes, high blood pressure, cancer, heart disease, or others)

--

Please list all allergies (such as to drugs, foods, pollen or others)

Latex, adhesive, pine
-----------------------

List any other important information about the person (such as smoking, pregnancy, alcohol use, etc.)

Vape
------

List all current prescription medications and medical devices being used.

--

List all over-the-counter medications and any vitamins, minerals, supplements, and herbal remedies being used.

Tylenol, ibuprofen, diclofenac
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#### Section F - About the Person Filling Out This Form

1 of 1

Primary?	Yes
Reporter is Patient?	
Title	
Last name	(b) (6)
Middle Name	
First name	(b) (6)
Number/Street	(b) (6)
City	(b) (6)
State/Province	(b) (6)
Country	UNITED STATES
ZIP or Postal code	(b) (6)
Telephone number	(b) (6)
Email address	(b) (6)

Fax	
Reporter Organization	
Department	
Reporter Speciality	
Today's date	23-Jun-2024
Did you report this problem to the company that makes the product (the manufacturer/compounder)?	No
If you do NOT want your identity disclosed to the manufacturer, please mark this box (Confidentiality Requested):	No

LEADING FORM OF MICRODOSING

ENHANCED  
INGREDIENTS

DIA MOND  
**SIRIUS**<sup>TM</sup>

PREMIUM MICRODOSE CHOCOLATE



DARK CHOCOLATE  
15 PIECE NET WEIGHT 1.6 OZ



All dates displayed in the report are in EST(GMT-05:00) time zone

**Basic Details**

Company Unit	CDER-CTU	Originating Account	FAERS
Source Medium	MWO (Drug)	Source Form Type	E2B XML 3500B
Priority	Routine		
Override Auto Calculation Rule	No		
FDA Received Date	23-Jun-2024	CTU Received Date	23-Jun-2024
CTU Triage Date		CTU Data Entry Date	
Report Type	Spontaneous	Report Classification	Drug
Assign To	User		
User/Group			
Forward to Department	<input checked="" type="checkbox"/>		
Case Priority	Direct		

**Contact**

Case Reporter	First Name	Last Name	Email Address	Phone
<input checked="" type="checkbox"/>	(b) (6)	(b) (6)	(b) (6)	(b) (6)

**Section A - About the Problem**

What kind of problem was it? (Check all that apply)	<input checked="" type="checkbox"/> Were hurt or had a bad side effect (including new or worsening symptoms) <input type="checkbox"/> Used a product incorrectly which could have or led to a problem <input type="checkbox"/> Noticed a problem with the quality of the product <input type="checkbox"/> Had problems after switching from one product maker to another maker
Date the problem occurred	19-Apr-2024
Serious	Yes
Did any of the following happen? (Check all that apply)	<input checked="" type="checkbox"/> Hospitalization - admitted or stayed longer <input type="checkbox"/> Required help to prevent permanent harm <input type="checkbox"/> Disability or health problem <input type="checkbox"/> Birth defect <input type="checkbox"/> Life-threatening <input type="checkbox"/> Death <input type="checkbox"/> Other serious/important medical incident(Please Describe Below)

**4. Tell us what happened and how it happened (Include as many details as possible FDA may reach out to you for any additional documents if necessary)**

Went into a vape shop looking for supplements to help relax like lions mane or chaga. Found the diamond shrumpz chocolate bar and read the label, scanned the lab test qr and asked every question we could, no red flags, so me and my boyfriend took half a bar each. Approx. 30 minutes later we were both having seizures and having hallucinations (tripping). We were vomiting uncontrollably, and my boyfriend ended up being conscious enough at one point to call 911. Arrived at the ER at around 10:30 pm and was not released until 8 am the next morning. Low blood pressure, high heart rate, seizures, unconscious for approx. 30 minutes each bout. Didn't fully recover until about 5 days later.
--

**Relevant Test/Laboratory Data**

1 of 1

Test Name		Test Date	19-Apr-2024
Test Result		Test Unit	
Low Test Range		High Test Range	

	More Information Available?	
--	-----------------------------	--

**Additional Comments**

	Not exactly what tests were done, but I know they did a full toxicity report and nothing came back.	
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**Section B - Product Availability**

Do you still have the product in case we need to evaluate it?	Yes
Do you have a picture of the product? (check yes if you are including a picture)	Yes

**Section C - About the Products**

1 of 1

Suspect	Yes	
Primary?	Yes	
Type	Drug/Biologic	
This report is about	Dietary Supplement	
Name of the product as it appears on the box, bottle, or package (Include as many names as you see)	Diamond Shrumz	
Name of the company that makes (or compounds) the product	Prophet Premium Blends	
Product Type(check all that apply)	<input checked="" type="checkbox"/> Over-the-Counter <input type="checkbox"/> Compounded by a Pharmacy or an Outsourcing Facility <input type="checkbox"/> Generic <input type="checkbox"/> Biosimilar	
Strength		If Other
NDC number		
Did the problem stop after the person reduced the dose or stopped taking or using the product?	No	
Did the problem return if the person started taking or using the product again?	Doesn't Apply	

**Drug Therapy**

1 of 1

Expiration date	01-Jul-2025	
Lot number	0011	
Dosage Form		
Quantity		If Other
Frequency		If Other
How was it taken or used	Oral	If Other
Date the person first started taking or using the product		
Date the person stopped taking or using the product		

Date the person reduced dose of the product	
Give best estimate of duration	10 Hour
Is therapy still on-going?	
Why was the person using the product? (such as what condition was it supposed to treat) <span style="float: right;">1 of 1</span>	
Relaxation	

Returned to Manufacturer On	
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#### Section D - About the Medical Device

Name of medical device	
Name of the company that makes the medical device	

Other identifying information (The model, catalog, lot, serial, or UDI number, and the expiration date, if you can locate them)

Model Number	
Catalog Number	
Lot Number	
Serial Number	
UDI Number	
Expiration date	
Was someone operating the medical device when the problem occurred?	

#### For implanted medical devices ONLY (such as pacemakers, breast implants, etc.)

Date the implant was put in		Date the implant was taken out (If relevant)	
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#### Section E - About the Person Who Had the Problem

Person's Initials	(b) (6)
Sex	Female
Gender	Cisgender woman/girl
Please Specify Other Gender	
Age (specify unit of time for age)	24 Year(s)
Date of Birth	
Weight	60.75 kg
Ethnicity (Choose only one)	Not Hispanic/Latino
Race (Check all that apply)	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Asian

<input checked="" type="checkbox"/> White
<input type="checkbox"/> Black or African American

List known medical conditions (Such as diabetes, high blood pressure, cancer, heart disease, or others)

--

Please list all allergies (such as to drugs, foods, pollen or others)

Latex, adhesive, pine
-----------------------

List any other important information about the person (such as smoking, pregnancy, alcohol use, etc.)

Vape
------

List all current prescription medications and medical devices being used.

--

List all over-the-counter medications and any vitamins, minerals, supplements, and herbal remedies being used.

Tylenol, ibuprofen, diclofenac
--------------------------------

#### Section F - About the Person Filling Out This Form

1 of 1

Primary?	Yes
Reporter is Patient?	
Title	
Last name	(b) (6)
Middle Name	
First name	(b) (6)
Number/Street	(b) (6)
City	(b) (6)
State/Province	(b) (6)
Country	UNITED STATES
ZIP or Postal code	(b) (6)
Telephone number	(b) (6)
Email address	(b) (6)

Fax	
Reporter Organization	
Department	
Reporter Speciality	
Today's date	23-Jun-2024
Did you report this problem to the company that makes the product (the manufacturer/compounder)?	No
If you do NOT want your identity disclosed to the manufacturer, please mark this box (Confidentiality Requested):	No

LEADING FORM OF MICRODOSING

ENHANCED  
INGREDIENTS

DIA MOND  
**SIRIUS**<sup>TM</sup>

PREMIUM MICRODOSE CHOCOLATE



DARK CHOCOLATE  
15 PIECE NET WEIGHT 1.6 OZ



All dates displayed in the report are in EST(GMT-05:00) time zone

**Basic Details**

Company Unit	CDER-CTU	Originating Account	FAERS
Source Medium	MWO (Drug)	Source Form Type	E2B XML 3500B
Priority	Routine		
Override Auto Calculation Rule	No		
FDA Received Date	24-Jun-2024	CTU Received Date	24-Jun-2024
CTU Triage Date		CTU Data Entry Date	
Report Type	Spontaneous	Report Classification	Drug
Assign To	User		
User/Group			
Forward to Department	<input checked="" type="checkbox"/>		
Case Priority	Direct		

**Contact**

Case Reporter	First Name	Last Name	Email Address	Phone
<input checked="" type="checkbox"/>	(b) (6)	(b) (6)	(b) (6)	(b) (6)

**Section A - About the Problem**

What kind of problem was it? (Check all that apply)	<input checked="" type="checkbox"/> Were hurt or had a bad side effect (including new or worsening symptoms) <input type="checkbox"/> Used a product incorrectly which could have or led to a problem <input type="checkbox"/> Noticed a problem with the quality of the product <input type="checkbox"/> Had problems after switching from one product maker to another maker
Date the problem occurred	16-Jun-2024
Serious	Yes
Did any of the following happen? (Check all that apply)	<input checked="" type="checkbox"/> Hospitalization - admitted or stayed longer <input checked="" type="checkbox"/> Required help to prevent permanent harm <input type="checkbox"/> Disability or health problem <input type="checkbox"/> Birth defect <input checked="" type="checkbox"/> Life-threatening <input type="checkbox"/> Death <input checked="" type="checkbox"/> Other serious/important medical incident(Please Describe Below)
Other serious/important medical incident(Please Describe Below)	

4. Tell us what happened and how it happened (Include as many details as possible FDA may reach out to you for any additional documents if necessary)

My husband consumed Diamond Shrumz microdose chocolate[INVALID]s and cream on June 16, 2024. They were purchased from a store in New Jersey. I believe he consumed 2 out of the 15 bars. He also drank alcohol, his BAC was 0.07%. He may have also smoked Marijuana. I'm not sure what time he ingested the chocolate but he had multiple seizures and was medically induced for 2 days. At this point he is still dealing with slight neurological and short term memory issues.
--

**Relevant Test/Laboratory Data**

1 of 1

Test Name		Test Date	
Test Result		Test Unit	

Low Test Range		High Test Range	
More Information Available?			

### Additional Comments

(Leave blank if no additional comments)

### Section B - Product Availability

Do you still have the product in case we need to evaluate it?	Yes
Do you have a picture of the product? (check yes if you are including a picture)	Yes

### Section C - About the Products

1 of 1

Suspect	Yes
Primary?	Yes
Type	Drug/Biologic
This report is about	Food/Medical food
Name of the product as it appears on the box, bottle, or package (Include as many names as you see)	Premium microdose chocolate [INVALID]s & cream
Name of the company that makes (or compounds) the product	Diamond Shruumz
Product Type(check all that apply)	<input checked="" type="checkbox"/> Over-the-Counter <input type="checkbox"/> Compounded by a Pharmacy or an Outsourcing Facility <input type="checkbox"/> Generic <input type="checkbox"/> Biosimilar
Strength	If Other
NDC number	
Did the problem stop after the person reduced the dose or stopped taking or using the product?	Yes
Did the problem return if the person started taking or using the product again?	Doesn't Apply

### Drug Therapy

1 of 1

Expiration date	30-Jun-2025		
Lot number	0012		
Dosage Form			
Quantity	Other	If Other	2 Pieces
Frequency	Other	If Other	Used once
How was it taken or used	Oral	If Other	
Date the person first started taking or using the product	16-Jun-2024		

Date the person stopped taking or using the product	16-Jun-2024
Date the person reduced dose of the product	
Give best estimate of duration	
Is therapy still on-going?	
Why was the person using the product? (such as what condition was it supposed to treat) <span style="float: right;">1 of 1</span>	
He thought the product was natural for relaxation benefits	

Returned to Manufacturer On	
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Section D - About the Medical Device	
Name of medical device	
Name of the company that makes the medical device	
Other identifying information (The model, catalog, lot, serial, or UDI number, and the expiration date, if you can locate them)	
Model Number	
Catalog Number	
Lot Number	
Serial Number	
UDI Number	
Expiration date	
Was someone operating the medical device when the problem occurred?	

For implanted medical devices ONLY (such as pacemakers, breast implants, etc.)		
Date the implant was put in		Date the implant was taken out (If relevant)

Section E - About the Person Who Had the Problem	
Person's Initials	(b) (6)
Sex	Male
Gender	Cisgender man/boy
Please Specify Other Gender	
Age (specify unit of time for age)	
Date of Birth	(b) (6)
Weight	71 kg
Ethnicity (Choose only one)	Hispanic/Latino
Race (Check all that apply)	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander

- |                                     |                           |
|-------------------------------------|---------------------------|
| <input type="checkbox"/>            | Asian                     |
| <input type="checkbox"/>            | White                     |
| <input checked="" type="checkbox"/> | Black or African American |

## List known medical conditions (Such as diabetes, high blood pressure, cancer, heart disease, or others)

Renal disease HTN

## Please list all allergies (such as to drugs, foods, pollen or others)

Thymoglobulin

## List any other important information about the person (such as smoking, pregnancy, alcohol use, etc.)

Social drinker Marijuana

## List all current prescription medications and medical devices being used.

Nifedipine 90mg 1x day Coreg 25mg 1x day

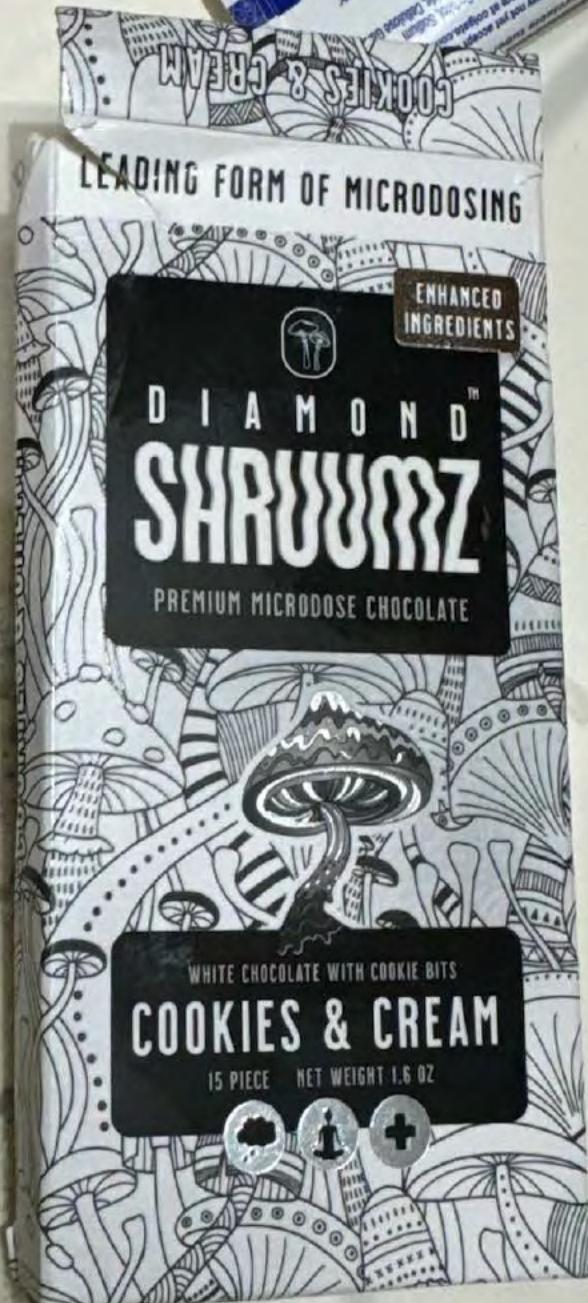
## List all over-the-counter medications and any vitamins, minerals, supplements, and herbal remedies being used.

## Section F - About the Person Filling Out This Form

1 of 1

Primary?	Yes
Reporter is Patient?	
Title	
Last name	(b) (6)
Middle Name	
First name	(b) (6)
Number/Street	(b) (6)
City	(b) (6)
State/Province	(b) (6)
Country	UNITED STATES
ZIP or Postal code	(b) (6)
Telephone number	(b) (6)
Email address	(b) (6)

Fax	
Reporter Organization	
Department	
Reporter Speciality	
Today's date	24-Jun-2024
Did you report this problem to the company that makes the product (the manufacturer/compounder)?	No
If you do NOT want your identity disclosed to the manufacturer, please mark this box (Confidentiality Requested):	No



WHITE CHOCOLATE WITH COOKIE BITS

**COOKIES & CREAM**

15 PIECE NET WEIGHT 1.6 OZ

All dates displayed in the report are in EST(GMT-05:00) time zone

**Basic Details**

Company Unit	CDER-CTU	Originating Account	FAERS
Source Medium	MWO (Drug)	Source Form Type	E2B XML 3500B
Priority	Routine		
Override Auto Calculation Rule	No		
FDA Received Date	25-Jun-2024	CTU Received Date	25-Jun-2024
CTU Triage Date		CTU Data Entry Date	
Report Type	Spontaneous	Report Classification	Drug
Assign To	User		
User/Group			
Forward to Department	<input checked="" type="checkbox"/>		
Case Priority	Direct		

**Contact**

Case Reporter	First Name	Last Name	Email Address	Phone
<input checked="" type="checkbox"/>	(b) (6)	(b) (6)	(b) (6)	(b) (6)

**Section A - About the Problem**

What kind of problem was it? (Check all that apply)	<input checked="" type="checkbox"/> Were hurt or had a bad side effect (including new or worsening symptoms) <input type="checkbox"/> Used a product incorrectly which could have or led to a problem <input type="checkbox"/> Noticed a problem with the quality of the product <input type="checkbox"/> Had problems after switching from one product maker to another maker
Date the problem occurred	27-Apr-2024
Serious	No
Did any of the following happen? (Check all that apply)	<input type="checkbox"/> Hospitalization - admitted or stayed longer <input checked="" type="checkbox"/> Required help to prevent permanent harm <input type="checkbox"/> Disability or health problem <input type="checkbox"/> Birth defect <input type="checkbox"/> Life-threatening <input type="checkbox"/> Death <input type="checkbox"/> Other serious/important medical incident(Please Describe Below)

4. Tell us what happened and how it happened (Include as many details as possible FDA may reach out to you for any additional documents if necessary)

My son purchased a Diamond Shrumz mushroom chocolate bar at (b) (6). Took the recommended dose as it was his first time trying these and his girlfriend came home from work to find him convulsing in his room. She requested assistance from his roommate who is pre-med. They put him on his side and called 911 while placing cool water on the back of his neck. FD came with an ambulance and transported him to the (b) (6) Medical Center. He does not remember anything after taking the dose until he was in the ER. He stated that at the time he purchased the bar, he went on the website for correct dosing and 8 squares was within range - as of today when we checked, the website now states 1-2 squares. At the hospital, he was unable to form coherent words and his girlfriend confirmed that he was seizing when she entered his room. We drove from an hour away and spoke with the FD on the way to provide medical background. When I contacted poison control after seeing the news articles, they stated that he should go for follow-up labs to make sure there was no liver damage - we haven't done that yet. I have contacted the company 3 emails and 2 voicemails and they have not replied.

**Relevant Test/Laboratory Data**

1 of 3

	Test Name	CATSCAN W/O CONTRAST	Test Date	27-Apr-2024	
	Test Result	No acute intracranial process.	Test Unit	UNKNOWN	
	Low Test Range		High Test Range		
	More Information Available?				

## Relevant Test/Laboratory Data

2 of 3

	Test Name	XRAY CHEST SINGLE VIEW	Test Date	27-Apr-2024	
	Test Result	No acute intrathoracic process.	Test Unit	UNKNOWN	
	Low Test Range		High Test Range		
	More Information Available?				

## Relevant Test/Laboratory Data

3 of 3

	Test Name	EKG	Test Date	27-Apr-2024	
	Test Result	Normal sinus rhythm Normal ECG	Test Unit		
	Low Test Range		High Test Range		
	More Information Available?				

## Additional Comments

	Presentation Chief Complaint Seizure, generalized Free Text HPI Notes Free Text HPI Notes 20-year-old male brought by EMS with the information that patient had not been seen by his girlfriend since yesterday. Girlfriend arrived few minutes later on stated that she spoke to him 2:00 a.m. and he was normal ,coherent coherent speech. Patient has a history of use of mushrooms.. Patient is awake alert but incoherent follows simple commands moving all extremities pupils equal. No obvious signs of trauma seen on the head neck in the body. The vital signs are stable no fever. No prior history of seizure as per EMS AMS - Altered Mental Status Unspecified convulsions 4/27/2024 Toxic effect of unspecified substance, accidental (unintentional), initial encounter 4/27/2024	
--	--	--

## Section B - Product Availability

	Do you still have the product in case we need to evaluate it?	No
	Do you have a picture of the product? (check yes if you are including a picture)	No

## Section C - About the Products

1 of 1

	Suspect	Yes
	Primary?	Yes
	Type	Drug/Biologic
	This report is about	Food/Medical food
	Name of the product as it appears on the box, bottle, or package (Include as many names as you see)	Diamond Shrumz[INVALID ]s and Cream Premium Microdose Chocolate
	Name of the company that makes (or compounds) the product	Diamond Shrumz
	Product Type(check all that apply)	<input checked="" type="checkbox"/> Over-the-Counter <input type="checkbox"/> Compounded by a Pharmacy or an Outsourcing Facility

Generic  
 Biosimilar

Strength		If Other	
NDC number			
Did the problem stop after the person reduced the dose or stopped taking or using the product?	Yes		
Did the problem return if the person started taking or using the product again?	Doesn't Apply		

Drug Therapy	1 of 1		
Expiration date			
Lot number			
Dosage Form			
Quantity	Other	If Other	8 squares
Frequency			
How was it taken or used	Oral	If Other	
Date the person first started taking or using the product	27-Apr-2024		
Date the person stopped taking or using the product	27-Apr-2024		
Date the person reduced dose of the product			
Give best estimate of duration			
Is therapy still on-going?			

Why was the person using the product? (such as what condition was it supposed to treat)	1 of 1
To relax (within the range on the website on that date)	

Returned to Manufacturer On	
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Section D - About the Medical Device	
Name of medical device	
Name of the company that makes the medical device	

Other identifying information (The model, catalog, lot, serial, or UDI number, and the expiration date, if you can locate them)	
Model Number	
Catalog Number	
Lot Number	
Serial Number	
UDI Number	

Expiration date	
Was someone operating the medical device when the problem occurred?	

|For implanted medical devices ONLY (such as pacemakers, breast implants, etc.)

Date the implant was put in		Date the implant was taken out (If relevant)
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|Section E - About the Person Who Had the Problem

Person's Initials	(b) (6)
Sex	Male
Gender	Cisgender man/boy
Please Specify Other Gender	
Age (specify unit of time for age)	
Date of Birth	(b) (6)
Weight	58.5 kg
Ethnicity (Choose only one)	Not Hispanic/Latino
Race (Check all that apply)	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Asian <input checked="" type="checkbox"/> White <input type="checkbox"/> Black or African American

|List known medical conditions (Such as diabetes, high blood pressure, cancer, heart disease, or others)

None
------

|Please list all allergies (such as to drugs, foods, pollen or others)

None
------

|List any other important information about the person (such as smoking, pregnancy, alcohol use, etc.)

None
------

|List all current prescription medications and medical devices being used.

None
------

|List all over-the-counter medications and any vitamins, minerals, supplements, and herbal remedies being used.

	None	
--	------	--

## Section F - About the Person Filling Out This Form

1 of 1

Primary?	Yes
Reporter is Patient?	
Title	
Last name	(b) (6)
Middle Name	
First name	(b) (6)
Number/Street	
City	(b) (6)
State/Province	(b) (6)
Country	UNITED STATES
ZIP or Postal code	(b) (6)
Telephone number	(b) (6)
Email address	(b) (6)
Fax	
Reporter Organization	
Department	
Reporter Speciality	
Today's date	25-Jun-2024
Did you report this problem to the company that makes the product (the manufacturer/compounder)?	Yes
If you do NOT want your identity disclosed to the manufacturer, please mark this box (Confidentiality Requested):	No

All dates displayed in the report are in EST(GMT-05:00) time zone

**Basic Details**

Company Unit	CDER-CTU	Originating Account	FAERS
Source Medium	MWO (Drug)	Source Form Type	E2B XML 3500B
Priority	Routine		
Override Auto Calculation Rule	No		
FDA Received Date	25-Jun-2024	CTU Received Date	25-Jun-2024
CTU Triage Date		CTU Data Entry Date	
Report Type	Spontaneous	Report Classification	Drug
Assign To	User		
User/Group			
Forward to Department	<input checked="" type="checkbox"/>		
Case Priority	Direct		

**Contact**

Case Reporter	First Name	Last Name	Email Address	Phone
<input checked="" type="checkbox"/>	(b) (6)	(b) (6)	(b) (6)	(b) (6)

**Section A - About the Problem**

What kind of problem was it? (Check all that apply)	<input checked="" type="checkbox"/> Were hurt or had a bad side effect (including new or worsening symptoms) <input type="checkbox"/> Used a product incorrectly which could have or led to a problem <input type="checkbox"/> Noticed a problem with the quality of the product <input type="checkbox"/> Had problems after switching from one product maker to another maker
Date the problem occurred	11-May-2024
Serious	Yes
Did any of the following happen? (Check all that apply)	<input type="checkbox"/> Hospitalization - admitted or stayed longer <input type="checkbox"/> Required help to prevent permanent harm <input type="checkbox"/> Disability or health problem <input type="checkbox"/> Birth defect <input type="checkbox"/> Life-threatening <input type="checkbox"/> Death <input checked="" type="checkbox"/> Other serious/important medical incident(Please Describe Below)
Other serious/important medical incident(Please Describe Below)	

4.Tell us what happened and how it happened (Include as many details as possible FDA may reach out to you for any additional documents if necessary)

I purchased two Diamond brand chocolate mushroom candy bars, Fruity Cereal and [INVALID] Butter. I took 3 squares of the [INVALID] butter and about 45 minutes later I was walking in my house, and while I was walking and active I blacked out and fell to the ground. I didn't seek medical attention, however my back and arm were very sore for the next 5 days. A week after this event I ate 3 squares of the fruity cereal bar, I didn't link the first event to the mushroom chocolate at this point. A couple hours after eating them I was tired, so I went to sleep. 45 minutes later I woke up to my Mother yelling to me, asking if I was ok. When I "came to" I was completely naked, sitting on my toilet, but bent over forward using my hands/fingernails to dig through an Imaginary hole in the floor looking for toilet paper! The last thing I remember was yelling out to my Mom, "I need toilet paper" and then I blacked out again. When I "came to" again, my Mother was trying to hand me a shirt. Apparently I had asked for a shirt instead of toilet paper. My Mom then pointed out that I had a roll in my hand. She left, I finished up, but then on my way back to bed I blacked out again, hitting my knee and my head. I finally made it back to bed and slept the whole night. For the next week I had a very sore head and knee. I threw the product away when I read that the recommendation was to toss them out.	
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## Relevant Test/Laboratory Data

1 of 1

Test Name		Test Date	
Test Result		Test Unit	
Low Test Range		High Test Range	
More Information Available?			

## Additional Comments

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## Section B - Product Availability

Do you still have the product in case we need to evaluate it?	No
Do you have a picture of the product? (check yes if you are including a picture)	Yes

## Section C - About the Products

1 of 1

Suspect	Yes	
Primary?	Yes	
Type	Drug/Biologic	
This report is about	Food/Medical food	
Name of the product as it appears on the box, bottle, or package (Include as many names as you see)	None	
Name of the company that makes (or compounds) the product	Diamond	
Product Type(check all that apply)	<input checked="" type="checkbox"/> Over-the-Counter <input type="checkbox"/> Compounded by a Pharmacy or an Outsourcing Facility <input type="checkbox"/> Generic <input type="checkbox"/> Biosimilar	
Strength		If Other
NDC number		
Did the problem stop after the person reduced the dose or stopped taking or using the product?	Yes	
Did the problem return if the person started taking or using the product again?	Doesn't Apply	

## Drug Therapy

1 of 1

Expiration date			
Lot number			
Dosage Form			
Quantity	Other	If Other	2 Bars

Frequency	Other	If Other	Whenever
How was it taken or used	Oral	If Other	
Date the person first started taking or using the product	11-May-2024		
Date the person stopped taking or using the product	28-May-2024		
Date the person reduced dose of the product			
Give best estimate of duration			
Is therapy still on-going?			

Why was the person using the product? (such as what condition was it supposed to treat)

1 of 1

Experimentation	
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Returned to Manufacturer On	
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**Section D - About the Medical Device**

Name of medical device	
Name of the company that makes the medical device	

Other identifying information (The model, catalog, lot, serial, or UDI number, and the expiration date, if you can locate them)

Model Number	
Catalog Number	
Lot Number	
Serial Number	
UDI Number	
Expiration date	
Was someone operating the medical device when the problem occurred?	

**For implanted medical devices ONLY (such as pacemakers, breast implants, etc.)**

Date the implant was put in		Date the implant was taken out (If relevant)	
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**Section E - About the Person Who Had the Problem**

Person's Initials	(b) (6)
Sex	Female
Gender	Cisgender woman/girl
Please Specify Other Gender	
Age (specify unit of time for age)	48 Year(s)
Date of Birth	

Weight	108 kg
Ethnicity (Choose only one)	Not Hispanic/Latino
Race (Check all that apply)	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Asian <input checked="" type="checkbox"/> White <input type="checkbox"/> Black or African American

## List known medical conditions (Such as diabetes, high blood pressure, cancer, heart disease, or others)

Diabetes, High Blood Pressure, High Cholesterol, Acid Reflux, and Depression
--

## Please list all allergies (such as to drugs, foods, pollen or others)

Penicillin and Amoxicillin, Metformin, Ozempic
--

## List any other important information about the person (such as smoking, pregnancy, alcohol use, etc.)

Sometimes smokes marijuana
----------------------------

## List all current prescription medications and medical devices being used.

70/30 N Insulin, Lisinopril, Atorvastatin, Prilosec, Oxybutynin, Wellbutrin (not taking at the time of events) and citalopram
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## List all over-the-counter medications and any vitamins, minerals, supplements, and herbal remedies being used.

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## Section F - About the Person Filling Out This Form

1 of 1

Primary?	Yes
Reporter is Patient?	
Title	
Last name	(b) (6)
Middle Name	
First name	(b) (6)
Number/Street	(b) (6)
City	(b) (6)
State/Province	(b) (6)

Country	UNITED STATES
ZIP or Postal code	(b) (6)
Telephone number	(b) (6)
Email address	(b) (6)
Fax	
Reporter Organization	
Department	
Reporter Speciality	
Today's date	25-Jun-2024
Did you report this problem to the company that makes the product (the manufacturer/compounder)?	No
If you do NOT want your identity disclosed to the manufacturer, please mark this box (Confidentiality Requested):	No



All dates displayed in the report are in EST(GMT-05:00) time zone

**Basic Details**

Company Unit	CDER-CTU	Originating Account	FAERS
Source Medium	MWO (Drug)	Source Form Type	E2B XML 3500
Priority	Routine		
Override Auto Calculation Rule	No		
FDA Received Date	30-Jun-2024	CTU Received Date	30-Jun-2024
CTU Triage Date		CTU Data Entry Date	
Report Type	Spontaneous	Report Classification	Drug
Assign To	User		
User/Group			
Forward to Department	<input checked="" type="checkbox"/>		
Case Priority	Direct		

**Contact**

Case Reporter	First Name	Last Name	Email Address	Phone
<input checked="" type="checkbox"/>	(b) (6)	(b) (6)	(b) (6)	(b) (6)

**A. PATIENT INFORMATION**

Patient Identifier (In Confidence)	(b) (6)
Age	
Date of Birth	(b) (6)
Sex	Male
Gender	Cisgender man/boy
Please Specify Other Gender	
Weight	
Ethnicity (Check single best answer)	
Race (Check all that apply)	<input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian or Other Pacific Islander

**B. ADVERSE EVENT, PRODUCT PROBLEM**

Type of Report (check all that apply)	<input checked="" type="checkbox"/> Adverse Event <input type="checkbox"/> Product Use/Medication Error <input type="checkbox"/> Product Problem (e.g., defects/malfunctions) <input type="checkbox"/> Problem with Different Manufacturer of Same Medicine
Serious	Yes
Outcome Attributed to Adverse Event (Check all that apply)	<input type="checkbox"/> Death <input checked="" type="checkbox"/> Life Threatening <input checked="" type="checkbox"/> Hospitalization (initial or prolonged) <input type="checkbox"/> Other Serious or Important Medical Events <input type="checkbox"/> Disability or Permanent Damage

- |                          |  |
|--------------------------|--|
| <input type="checkbox"/> | Congenital Anomaly/Birth Defects                             |
| <input type="checkbox"/> | Required Intervention to Prevent Permanent Impairment/Damage |

Date of Death	
Date of Event	22-Jun-2024
Date of this Report	30-Jun-2024

**| Describe Event, Problem or Product Use Error**

Describe Event, Problem, or Product Use Error: Pt arrived to ER unresponsive via EMS after eating 12 diamond shruumz chocolate bar pieces. Wife found him vomiting inside bathroom. He was ataxic, unable to stand. By the time EMS arrived, he was only responding to pain. He was intubated for GCS of 6.

**| Relevant Test/Laboratory Data**

1 of 1

Test Name		Test Date	
Test Result		Test Unit	
Low Test Range		High Test Range	
More Information Available?			

**| Additional Comments**

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**| Other Relevant History, Including Preexisting Medical Conditions**

Type 1 diabetes, ADHD, anxiety, depression	
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**| C. PRODUCT AVAILABILITY**

Product Available for Evaluation? (Do not send product to FDA)	No
Returned to Manufacturer on	
Do you have a picture of the product? (check yes if you are including a picture)	No

**| D. PRODUCT(S)**

1 of 5

Suspect	Yes	
Primary?	Yes	
Type	Drug/Biologic	
This report involves:	Food/Medical food	

**| Name, Strength, Manufacturer/Compounder (from product label)**

Product Name	Diamond Shruumz premium microdose chocolate- dark chocolate	
Strength		If Other
Manufacturer/Compounder		
NDC# or Unique ID		

	Product Type(check all that apply)	<input checked="" type="checkbox"/> OTC <input type="checkbox"/> Compounded <input type="checkbox"/> Generic <input type="checkbox"/> Biosimilar	
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	Event Abated After Use Stopped or Dose Reduced?	Yes	
--	---	-----	--

	Event Reappeared after Reintroduction ?	Doesn't Apply	
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### Drug Therapy 1 of 1

Dose or Amount		If Other	
Frequency		If Other	
Route		If Other	
Dosage Form			
Start	22-Jun-2024		
Stop	22-Jun-2024		
Dose Reduced			
Therapy Duration		If Other	
Is therapy still on-going?	No		
Lot Number			
Expiration Date			

### Diagnosis for Use (indication) 1 of 1

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### D. PRODUCT(S) 2 of 5

Concomitant	Yes		
Primary?			
Type	Drug/Biologic		
This report involves:			

### Name,Strength,Manufacturer/Compounder (from product label)

Product Name	adderall xr 20		
Strength		If Other	
Manufacturer/Compounder			
NDC# or Unique ID			

Product Type(check all that apply)	<input type="checkbox"/> OTC <input type="checkbox"/> Compounded <input type="checkbox"/> Generic <input type="checkbox"/> Biosimilar		
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Event Abated After Use Stopped or Dose Reduced?			
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Event Reappeared after Reintroduction ?			
---	--	--	--

### Drug Therapy 1 of 1

Dose or Amount		If Other	
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Frequency		If Other	
Route		If Other	
Dosage Form			
Start			
Stop			
Dose Reduced			
Therapy Duration		If Other	
Is therapy still on-going?			
Lot Number			
Expiration Date			
Diagnosis for Use (indication)			
1 of 1			

D. PRODUCT(S) <span style="float: right;">3 of 5</span>			
Concomitant	Yes		
Primary?			
Type	Drug/Biologic		
This report involves:			
Name, Strength, Manufacturer/Compounder (from product label)			
Product Name	cymbalta 30		
Strength		If Other	
Manufacturer/Compounder			
NDC# or Unique ID			
Product Type(check all that apply)	<input type="checkbox"/> OTC <input type="checkbox"/> Compounded <input type="checkbox"/> Generic <input type="checkbox"/> Biosimilar		
Event Abated After Use Stopped or Dose Reduced?			
Event Reappeared after Reintroduction ?			

Drug Therapy <span style="float: right;">1 of 1</span>			
Dose or Amount		If Other	
Frequency		If Other	
Route		If Other	
Dosage Form			
Start			
Stop			
Dose Reduced			
Therapy Duration		If Other	
Is therapy still on-going?			
Lot Number			

	Expiration Date	
Diagnosis for Use (indication)		1 of 1

D. PRODUCT(S)		4 of 5
	Concomitant	Yes
	Primary?	
	Type	Drug/Biologic
	This report involves:	

Name, Strength, Manufacturer/Compounder (from product label)		
Product Name	albuterol inhaler	
Strength		If Other
Manufacturer/Compounder		
NDC# or Unique ID		
Product Type (check all that apply)	<input type="checkbox"/> OTC <input type="checkbox"/> Compounded <input type="checkbox"/> Generic <input type="checkbox"/> Biosimilar	
Event Abated After Use Stopped or Dose Reduced?		
Event Reappeared after Reintroduction ?		

Drug Therapy		
Dose or Amount		If Other
Frequency		If Other
Route		If Other
Dosage Form		
Start		
Stop		
Dose Reduced		
Therapy Duration		If Other
Is therapy still on-going?		
Lot Number		
Expiration Date		

Diagnosis for Use (indication)		1 of 1

D. PRODUCT(S)		5 of 5
	Concomitant	Yes
	Primary?	

Type	Drug/Biologic		
This report involves:			
<b>Name, Strength, Manufacturer/Compounder (from product label)</b>			
Product Name	novolog		
Strength		If Other	
Manufacturer/Compounder			
NDC# or Unique ID			
Product Type (check all that apply)	<input type="checkbox"/> OTC <input type="checkbox"/> Compounded <input type="checkbox"/> Generic <input type="checkbox"/> Biosimilar		
Event Abated After Use Stopped or Dose Reduced?			
Event Reappeared after Reintroduction ?			
<b>Drug Therapy</b> 1 of 1			
Dose or Amount		If Other	
Frequency		If Other	
Route		If Other	
Dosage Form			
Start			
Stop			
Dose Reduced			
Therapy Duration		If Other	
Is therapy still on-going?			
Lot Number			
Expiration Date			
<b>Diagnosis for Use (indication)</b> 1 of 1			
<b>E. SUSPECT MEDICAL DEVICE</b>			
Brand Name			
Common Device Name			
Procode			
Manufacturer Name			
City			
State			
Model #			
Lot #			
Catalog #			
Expiration Date			
Serial #			

Unique Identifier (UDI) #	
Operator of Device	<input type="checkbox"/> Health Professional <input type="checkbox"/> Patient/Consumer <input type="checkbox"/> Other
Other	
If Implanted, Give Date	
If Explanted, Give Date	
Is this a single-use device that was reprocessed and reused on a patient?	
If Yes for the above field, Enter Name and Address of Reprocessor	
Was this device serviced by a third party?	

**F. OTHER (CONCOMITANT) MEDICAL PRODUCTS****CONCOMITANT MEDICAL PRODUCT DESCRIPTION**

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**G. REPORTER**

1 of 1

Primary?	Yes	
Reporter is Patient?		
Title		
Last Name	(b) (6)	
Middle Name		
First Name	(b) (6)	
Address	(b) (6)	
City	(b) (6)	
State/Province/Region	(b) (6)	
Country	UNITED STATES	If Other
ZIP/Postal Code	(b) (6)	
Phone	(b) (6)	
Email	(b) (6)	
Fax		
Reporter Organization		
Department		
Reporter Speciality		
Health Professional?	Yes	
Occupation	Pharmacist	If Other
Also Reported to	<input checked="" type="checkbox"/> Manufacturer/Compounder <input type="checkbox"/> User Facility <input type="checkbox"/> Distributor/Importer	

If you do NOT want your identity disclosed to the manufacturer	Yes
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All dates displayed in the report are in EST(GMT-05:00) time zone

**Basic Details**

Company Unit	CDER-CTU	Originating Account	FAERS
Source Medium	MWO (Drug)	Source Form Type	E2B XML 3500B
Priority	Routine		
Override Auto Calculation Rule	No		
FDA Received Date	03-Jul-2024	CTU Received Date	03-Jul-2024
CTU Triage Date		CTU Data Entry Date	
Report Type	Spontaneous	Report Classification	Drug
Assign To	User		
User/Group			
Forward to Department	<input checked="" type="checkbox"/>		
Case Priority	Direct		

**Contact**

Case Reporter	First Name	Last Name	Email Address	Phone
<input checked="" type="checkbox"/>	(b) (6)	(b) (6)	(b) (6)	(b) (6)

**Section A - About the Problem**

What kind of problem was it? (Check all that apply)	<input checked="" type="checkbox"/> Were hurt or had a bad side effect (including new or worsening symptoms) <input type="checkbox"/> Used a product incorrectly which could have or led to a problem <input type="checkbox"/> Noticed a problem with the quality of the product <input type="checkbox"/> Had problems after switching from one product maker to another maker
Date the problem occurred	30-Jun-2024
Serious	Yes
Did any of the following happen? (Check all that apply)	<input checked="" type="checkbox"/> Hospitalization - admitted or stayed longer <input checked="" type="checkbox"/> Required help to prevent permanent harm <input type="checkbox"/> Disability or health problem <input type="checkbox"/> Birth defect <input checked="" type="checkbox"/> Life-threatening <input type="checkbox"/> Death <input type="checkbox"/> Other serious/important medical incident(Please Describe Below)

4. Tell us what happened and how it happened (Include as many details as possible FDA may reach out to you for any additional documents if necessary)

I took half of a [INVALID]s & Cream Diamond Shrumz bar. I started to feel nauseous and then a heavy feeling in my chest. I remember about 3 hours after ingestion I thought I had died and was stuck alone on the planet, I tried to find any way to kill myself to make it end. (Note: This next part was during a 4 hour gap here where I remember absolutely nothing, this is what was told to me at the hospital) My neighbors heard me screaming outside, apparently I was not clothed, and they called first responders. The next thing I remember I was in the floor of my living room covered in vomit regaining consciousness as the officers came inside to make sure I was okay. As far as physical injuries go, I have quite a few bruises and a pretty good sized knot on my head. I wouldn't wish this psychological torment on anyone.
---

**Relevant Test/Laboratory Data**

1 of 1

Test Name		Test Date	
Test Result		Test Unit	
Low Test Range		High Test Range	

	More Information Available?	
<b>Additional Comments</b>		
<b>Section B - Product Availability</b>		
Do you still have the product in case we need to evaluate it?	No	
Do you have a picture of the product? (check yes if you are including a picture)	Yes	
<b>Section C - About the Products</b> <span style="float: right;">1 of 1</span>		
Suspect	Yes	
Primary?	Yes	
Type	Drug/Biologic	
This report is about	Food/Medical food	
Name of the product as it appears on the box, bottle, or package (Include as many names as you see)	Diamond Shrumz	
Name of the company that makes (or compounds) the product	Prophet Premium Blends	
Product Type(check all that apply)	<input type="checkbox"/> Over-the-Counter <input type="checkbox"/> Compounded by a Pharmacy or an Outsourcing Facility <input type="checkbox"/> Generic <input type="checkbox"/> Biosimilar	
Strength	NOT LISTED mg milligram(s)	If Other
NDC number		
Did the problem stop after the person reduced the dose or stopped taking or using the product?	Yes	
Did the problem return if the person started taking or using the product again?	Doesn't Apply	
<b>Drug Therapy</b> <span style="float: right;">1 of 1</span>		
Expiration date	01-Jun-2025	
Lot number		
Dosage Form		
Quantity	If Other	
Frequency	If Other	
How was it taken or used	If Other	
Date the person first started taking or using the product		

Date the person stopped taking or using the product	
Date the person reduced dose of the product	
Give best estimate of duration	12 Hour
Is therapy still on-going?	
Why was the person using the product? (such as what condition was it supposed to treat)	

1 of 1

Returned to Manufacturer On	
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Section D - About the Medical Device	
Name of medical device	
Name of the company that makes the medical device	
Other identifying information (The model, catalog, lot, serial, or UDI number, and the expiration date, if you can locate them)	
Model Number	
Catalog Number	
Lot Number	
Serial Number	
UDI Number	
Expiration date	
Was someone operating the medical device when the problem occurred?	

For implanted medical devices ONLY (such as pacemakers, breast implants, etc.)		
Date the implant was put in		Date the implant was taken out (If relevant)

Section E - About the Person Who Had the Problem	
Person's Initials	(b) (6)
Sex	Female
Gender	Cisgender woman/girl
Please Specify Other Gender	
Age (specify unit of time for age)	23 Year(s)
Date of Birth	
Weight	108 kg
Ethnicity (Choose only one)	Not Hispanic/Latino
Race (Check all that apply)	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander

- |                                     |                           |
|-------------------------------------|---------------------------|
| <input type="checkbox"/>            | Asian                     |
| <input checked="" type="checkbox"/> | White                     |
| <input type="checkbox"/>            | Black or African American |

List known medical conditions (Such as diabetes, high blood pressure, cancer, heart disease, or others)

--	--

Please list all allergies (such as to drugs, foods, pollen or others)

--	--

List any other important information about the person (such as smoking, pregnancy, alcohol use, etc.)

--	--

List all current prescription medications and medical devices being used.

--	--

List all over-the-counter medications and any vitamins, minerals, supplements, and herbal remedies being used.

--	--

#### Section F - About the Person Filling Out This Form

1 of 1

Primary?	Yes
Reporter is Patient?	
Title	
Last name	(b) (6)
Middle Name	
First name	(b) (6)
Number/Street	(b) (6)
City	(b) (6)
State/Province	(b) (6)
Country	UNITED STATES
ZIP or Postal code	(b) (6)
Telephone number	(b) (6)
Email address	(b) (6)

Fax	
Reporter Organization	
Department	
Reporter Speciality	
Today's date	03-Jul-2024
Did you report this problem to the company that makes the product (the manufacturer/compounder)?	No
If you do NOT want your identity disclosed to the manufacturer, please mark this box (Confidentiality Requested):	Yes

## ⚠️ WARNINGS AND DISCLAIMERS

- ◆ Never attempt to operate any form of heavy machinery or moving vehicle while using this product.
- ◆ Intoxicating effects of this product may be delayed.
- ◆ Warning: if consumed, may cause drowsiness.
- ◆ Warning: if consumed, may cause spiritual experience.
- ◆ Consult a doctor before consuming this product.
- ◆ Do not use this product if you are pregnant or nursing.
- ◆ 21 and over only!
- ◆ KEEP AWAY FROM CHILDREN AND PETS.

### THIS IS NOT AN FDA APPROVED PRODUCT

These statements have not been evaluated by the FDA. This product is not intended to diagnose, treat, cure, or prevent any disease. The purchaser of this product bears all risk and assumes all liability associated with the use, purchase, and possession of this product.

### INGREDIENTS      Allergens: Wheat

Cocoa Mass, Soy Lecithin, Sugar, Cocoa Butter, Milk, Corn Syrup, Cornstarch, Artificial Coloring, MCT Oil, Quantum Kava Liposome, Ashwagandha Extract, GABA, 5-HTP, Phosphatidylcholine, Caffeine Anhydrous, Muscimol, Lions Mane Mushroom Extract (Standardized to 30% Polysaccharides), Reishi Mushroom Extract, Chaga Mushroom Extract, and Rhodiola Rosea Extract.

#### DISTRIBUTED BY:

Prophet Premium Blends  
2413 S. Broadway  
Santa Ana, CA 92707

LAB TESTED



Batch: 0012

Expiration Date: June, 2025

LEADING FORM OF MICRODOSING



All dates displayed in the report are in EST(GMT-05:00) time zone

**Basic Details**

Company Unit	CDER-CTU	Originating Account	FAERS
Source Medium	MWO (Drug)	Source Form Type	E2B XML 3500B
Priority	Routine		
Override Auto Calculation Rule	No		
FDA Received Date	03-Jul-2024	CTU Received Date	03-Jul-2024
CTU Triage Date		CTU Data Entry Date	
Report Type	Spontaneous	Report Classification	Drug
Assign To	User		
User/Group			
Forward to Department	<input checked="" type="checkbox"/>		
Case Priority	Direct		

**Contact**

Case Reporter	First Name	Last Name	Email Address	Phone
<input checked="" type="checkbox"/>	(b) (6)	(b) (6)		

**Section A - About the Problem**

What kind of problem was it? (Check all that apply)	<input checked="" type="checkbox"/> Were hurt or had a bad side effect (including new or worsening symptoms) <input type="checkbox"/> Used a product incorrectly which could have or led to a problem <input type="checkbox"/> Noticed a problem with the quality of the product <input type="checkbox"/> Had problems after switching from one product maker to another maker
Date the problem occurred	30-Jun-2024
Serious	Yes
Did any of the following happen? (Check all that apply)	<input checked="" type="checkbox"/> Hospitalization - admitted or stayed longer <input type="checkbox"/> Required help to prevent permanent harm <input type="checkbox"/> Disability or health problem <input type="checkbox"/> Birth defect <input type="checkbox"/> Life-threatening <input type="checkbox"/> Death <input type="checkbox"/> Other serious/important medical incident(Please Describe Below)

4. Tell us what happened and how it happened (Include as many details as possible FDA may reach out to you for any additional documents if necessary)

After consuming 1 half bar of Dimond Shrumz premium microdose chocolate[INVALID]s and cream (batch 0012) for recreation, I fell into complete psychosis after 1.5 - 2 hours. Shortly after I have been told I fell in the bath and got help out to my bed where after a while I seized for less than 10 seconds which is when the full effects took control. I don't remember losing consciousness, but I eventually fell into 2 different, inexplicable scenes that defied the laws of time and space. The first was a seemingly slightly physical fight that didn't actually happen between myself and partner, except it occurred as an incomplete time loop that only changed by partial frames- experiencing the same thing what felt like thousands of times only developing by a tiny sound and new motion. I assume this was happening while my partner was holding me down preventing my unconscious body from physically abusing myself. It was frightening until it was suddenly over and I felt like I lost consciousness again then I suddenly fell into the next scene as if I was there the entire time. I assume this is when my partner left my side to experience her own horrors. What I saw in this "scene" seemed to be 4th dimensional for lack of a better explanation. I think I might have been going after my partner as she made her way outside making all sorts of trouble for herself. But it seemed every time I went through the door I was just back inside as if I had never walked out. Then something changed and it felt like a version of me had made a mistake in going through condensing the space I had to get through the door without making it look too different in an effort to get back to normal I panicked and made the mistake again until I was able to see was a thin line of what I had seen before surrounded by darkness that felt like a visualization of 2D from the side, as if I had altered the structure of the very space around me. I felt like I would be stuck in that space forever until my
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vision seemed to open back up and I saw the outside of the closed door when I lost any consciousness. I'm concerned I may have fallen down a half flight of stairs in this timeframe, but there is no confirmation. The next thing I saw was police and fire standing in the livingroom and I noticed I wasn't wearing cloths. This was followed by being brought out by my partner and making my presence known, answering questions about myself and how I got into my condition. The neighbors had called 911 some point prior because my partner caused lots of ruckus outside, but my condition was extremely concerning to everyone in the room as I was brutalized across my face and down the left side of my body. I have experience with hallucinogens of which none have been of this caliber. This was something I wouldn't wish on anyone. I could have done irreparable damage to my body while I was not present in the slightest. They took me to the trauma unit in an ambulance and did a CT scan. I'm lucky to have not taken more damage.

## Relevant Test/Laboratory Data

1 of 1

Test Name		Test Date	
Test Result		Test Unit	
Low Test Range		High Test Range	
More Information Available?			

## Additional Comments

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## Section B - Product Availability

Do you still have the product in case we need to evaluate it?	No
Do you have a picture of the product? (check yes if you are including a picture)	No

## Section C - About the Products

1 of 1

Suspect	Yes		
Primary?	Yes		
Type	Drug/Biologic		
This report is about	Food/Medical food		
Name of the product as it appears on the box, bottle, or package (Include as many names as you see)	Diamond Shrumz premium microdosing chocolate		
Name of the company that makes (or compounds) the product	Prophet premium blends		
Product Type(check all that apply)	<input checked="" type="checkbox"/> Over-the-Counter <input type="checkbox"/> Compounded by a Pharmacy or an Outsourcing Facility <input type="checkbox"/> Generic <input type="checkbox"/> Biosimilar		
Strength	Other	If Other	N/A
NDC number	N/A		
Did the problem stop after the person reduced the dose or stopped taking or using the product?	Yes		

Did the problem return if the person started taking or using the product again?	Doesn't Apply
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### Drug Therapy

1 of 1

Expiration date	30-Jun-2025		
Lot number	0012		
Dosage Form			
Quantity	Other	If Other	7.5 Tablet(s)
Frequency	Other	If Other	Once
How was it taken or used	Oral	If Other	
Date the person first started taking or using the product			
Date the person stopped taking or using the product			
Date the person reduced dose of the product			
Give best estimate of duration	9 Hour		
Is therapy still on-going?			

### Why was the person using the product? (such as what condition was it supposed to treat)

1 of 1

Recreational psychedelics
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Returned to Manufacturer On
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### Section D - About the Medical Device

Name of medical device	
Name of the company that makes the medical device	

Other identifying information (The model, catalog, lot, serial, or UDI number, and the expiration date, if you can locate them)

Model Number	
Catalog Number	
Lot Number	
Serial Number	
UDI Number	
Expiration date	
Was someone operating the medical device when the problem occurred?	

### For implanted medical devices ONLY (such as pacemakers, breast implants, etc.)

Date the implant was put in		Date the implant was taken out (If relevant)	
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## Section E - About the Person Who Had the Problem

Person's Initials	(b) (6)
Sex	Male
Gender	Cisgender man/boy
Please Specify Other Gender	
Age (specify unit of time for age)	23 Year(s)
Date of Birth	
Weight	63 kg
Ethnicity (Choose only one)	Not Hispanic/Latino
Race (Check all that apply)	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Asian <input checked="" type="checkbox"/> White <input type="checkbox"/> Black or African American

## List known medical conditions (Such as diabetes, high blood pressure, cancer, heart disease, or others)

N/A
-----

## Please list all allergies (such as to drugs, foods, pollen or others)

N/A
-----

## List any other important information about the person (such as smoking, pregnancy, alcohol use, etc.)

Regular nicotine(vape), delta 8 thc(vape), and alcohol use
--

## List all current prescription medications and medical devices being used.

N/A
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## List all over-the-counter medications and any vitamins, minerals, supplements, and herbal remedies being used.

I use fresh magnolia flower petals for their benefits while they are in season.
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## Section F - About the Person Filling Out This Form

1 of 1

Primary?	Yes
Reporter is Patient?	

Title	
Last name	(b) (6)
Middle Name	
First name	(b) (6)
Number/Street	
City	(b) (6)
State/Province	(b) (6)
Country	UNITED STATES
ZIP or Postal code	
Telephone number	
Email address	
Fax	
Reporter Organization	
Department	
Reporter Speciality	
Today's date	03-Jul-2024
Did you report this problem to the company that makes the product (the manufacturer/compounder)?	No
If you do NOT want your identity disclosed to the manufacturer, please mark this box (Confidentiality Requested):	Yes

All dates displayed in the report are in EST(GMT-05:00) time zone

**Basic Details**

Company Unit	CDER-CTU	Originating Account	FAERS
Source Medium	MWO (Drug)	Source Form Type	E2B XML 3500B
Priority	Routine		
Override Auto Calculation Rule	No		
FDA Received Date	04-Jul-2024	CTU Received Date	04-Jul-2024
CTU Triage Date		CTU Data Entry Date	
Report Type	Spontaneous	Report Classification	Drug
Assign To	User		
User/Group			
Forward to Department	<input checked="" type="checkbox"/>		
Case Priority	Direct		

**Contact**

Case Reporter	First Name	Last Name	Email Address	Phone
<input checked="" type="checkbox"/>	(b) (6)	(b) (6)	(b) (6)	(b) (6)

**Section A - About the Problem**

What kind of problem was it? (Check all that apply)	<input checked="" type="checkbox"/> Were hurt or had a bad side effect (including new or worsening symptoms) <input type="checkbox"/> Used a product incorrectly which could have or led to a problem <input type="checkbox"/> Noticed a problem with the quality of the product <input type="checkbox"/> Had problems after switching from one product maker to another maker
Date the problem occurred	03-Jul-2024
Serious	Yes
Did any of the following happen? (Check all that apply)	<input checked="" type="checkbox"/> Hospitalization - admitted or stayed longer <input type="checkbox"/> Required help to prevent permanent harm <input type="checkbox"/> Disability or health problem <input type="checkbox"/> Birth defect <input type="checkbox"/> Life-threatening <input type="checkbox"/> Death <input type="checkbox"/> Other serious/important medical incident(Please Describe Below)

**4. Tell us what happened and how it happened (Include as many details as possible FDA may reach out to you for any additional documents if necessary)**

My boyfriend is unconscious in the ER after eating a bar of Diamond Shrumz White Chocolate bar he bought from a smoke shop earlier today. He went to bed fine, then began excessively sweating in his sleep, so I tried to wake him. It took him 10 minutes to sit up after I was yelling at him to wake. He sat up and began vomiting. He tried to stand and tries to walk into the wall and fell to the floor. He didn't speak or seem to recognize me and didn't acknowledge I was there. He dedicated himself while intermittently vomiting. I called 911 and we are currently waiting on a room. He had the bar about 5 hours ago now and as of now, he has been non verbal and is currently unconscious.
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**Relevant Test/Laboratory Data**

1 of 1

Test Name		Test Date	
Test Result		Test Unit	
Low Test Range		High Test Range	

	More Information Available?	
<b>Additional Comments</b>		
<b>Section B - Product Availability</b>		
Do you still have the product in case we need to evaluate it?	No	
Do you have a picture of the product? (check yes if you are including a picture)	Yes	
<b>Section C - About the Products</b>		
1 of 1		
Suspect	Yes	
Primary?	Yes	
Type	Drug/Biologic	
This report is about	Food/Medical food	
Name of the product as it appears on the box, bottle, or package (Include as many names as you see)	Diamond Shruumz	
Name of the company that makes (or compounds) the product		
Product Type(check all that apply)	<input checked="" type="checkbox"/> Over-the-Counter <input type="checkbox"/> Compounded by a Pharmacy or an Outsourcing Facility <input type="checkbox"/> Generic <input type="checkbox"/> Biosimilar	
Strength		If Other
NDC number		
Did the problem stop after the person reduced the dose or stopped taking or using the product?		
Did the problem return if the person started taking or using the product again?		
<b>Drug Therapy</b>		
1 of 1		
Expiration date		
Lot number		
Dosage Form		
Quantity	Other	If Other
Frequency		
How was it taken or used	Oral	If Other
Date the person first started taking or using the product	03-Jul-2024	
Date the person stopped taking or using the product	03-Jul-2024	

Date the person reduced dose of the product	
Give best estimate of duration	
Is therapy still on-going?	
Why was the person using the product? (such as what condition was it supposed to treat) <span style="float: right;">1 of 1</span>	

Returned to Manufacturer On	
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#### Section D - About the Medical Device

Name of medical device	
Name of the company that makes the medical device	

Other identifying information (The model, catalog, lot, serial, or UDI number, and the expiration date, if you can locate them)

Model Number	
Catalog Number	
Lot Number	
Serial Number	
UDI Number	
Expiration date	
Was someone operating the medical device when the problem occurred?	

#### For implanted medical devices ONLY (such as pacemakers, breast implants, etc.)

Date the implant was put in		Date the implant was taken out (If relevant)	
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#### Section E - About the Person Who Had the Problem

Person's Initials	Unspecified
Sex	Male
Gender	Cisgender man/boy
Please Specify Other Gender	
Age (specify unit of time for age)	
Date of Birth	(b) (6)
Weight	90 kg
Ethnicity (Choose only one)	Hispanic/Latino
Race (Check all that apply)	<input checked="" type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Asian

White Black or African American

List known medical conditions (Such as diabetes, high blood pressure, cancer, heart disease, or others)

Please list all allergies (such as to drugs, foods, pollen or others)

None
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List any other important information about the person (such as smoking, pregnancy, alcohol use, etc.)

List all current prescription medications and medical devices being used.

Adderall Citalopram
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List all over-the-counter medications and any vitamins, minerals, supplements, and herbal remedies being used.

## Section F - About the Person Filling Out This Form

1 of 1

Primary?	Yes
Reporter is Patient?	
Title	
Last name	(b) (6)
Middle Name	
First name	(b) (6)
Number/Street	(b) (6)
City	(b) (6)
State/Province	(b) (6)
Country	UNITED STATES
ZIP or Postal code	(b) (6)
Telephone number	(b) (6)
Email address	(b) (6)

Fax	
Reporter Organization	
Department	
Reporter Speciality	
Today's date	04-Jul-2024
Did you report this problem to the company that makes the product (the manufacturer/compounder)?	No
If you do NOT want your identity disclosed to the manufacturer, please mark this box (Confidentiality Requested):	No

