

# SINGLE PATIENT INJECTION FORM



**IMPORTANT:** Before administering the injection, confirm there will be someone to accompany the patient after the 3-hour observation period. If this cannot be confirmed, do not give the injection.

Submit this information within 7 days after the patient's injections. If you are aware that the patient's prescriber has changed, please notify the ZYPREXA RELPREVV Patient Care Program Coordinating Center.

Patient No.:       (PIN)

Injection Facility Name:

Patient Name: \_\_\_\_\_  
 First MI Last

Date of Birth:   -   -      
 month day year

PDSS since the last visit? (After the patient left the office, following his/her previous injection, did the patient experience post-injection delirium/sedation syndrome?)

No  Yes

If Yes, has the prescriber been notified of the PDSS event?

Yes  No

## ZYPREXA RELPREVV TREATMENT

Date of Injection:   -   -      
 month day year

Time of ZYPREXA RELPREVV injection:   :    
 24-hour clock

Dose of Injection:  150 mg  210 mg  300 mg  405 mg  Other dose \_\_\_\_\_ mg

Was the patient observed for at least 3 hours post-injection?  Yes  No

Did the patient experience post-injection delirium/sedation syndrome during the onsite post-injection observational period?

No  Yes

If Yes, has the prescriber been notified of the PDSS event?  Yes  No

Following the injection, was the patient alert, oriented, and absent of any signs and symptoms of PDSS prior to being released from the healthcare facility?

Yes  No

Following the injection, was the patient accompanied from the facility?

Yes  No  Not applicable, patient did not leave facility (in-patient)

Was the patient or legal guardian given a Medication Guide prior to this injection?  Yes  No

Healthcare Facility Staff Member Signature \_\_\_\_\_ DATE:   -   -      
 month day year

Healthcare Facility Staff Member Name (print): \_\_\_\_\_

