

POST INJECTION DELIRIUM/SEDATION SYNDROME (PDSS) FORM PDSS
Page 1 of 3



Submit this information within **24 hours** of becoming aware of a suspected PDSS event.

Patient No.:
 (PIN)
 Patient Name: _____
 First Name MI Last Name
 Date of Birth: - -
month day year

Does the patient have a diagnosis of schizophrenia? Yes No

PATIENT/INJECTION INFORMATION

Date of Injection: - -
month day year

Convenience Kit Package
 Lot # _____

Time of ZYPREXA RELPREVV Injection: :
24-hour clock

ONSET OF FIRST PDSS SYMPTOM AFTER INJECTION (choose only one)

- | | | |
|--|--|---|
| <input type="checkbox"/> 1 - 15 minutes | <input type="checkbox"/> 46 - 60 minutes | <input type="checkbox"/> 121 - 150 minutes (2 ½ hours) |
| <input type="checkbox"/> 16 - 30 minutes | <input type="checkbox"/> 61 - 90 minutes (1 ½ hours) | <input type="checkbox"/> 151 - 180 minutes (3 hours) |
| <input type="checkbox"/> 31 - 45 minutes | <input type="checkbox"/> 91 - 120 minutes (2 hours) | <input type="checkbox"/> If greater than 3 hours please specify:
_____ Hours |

Dose of Injection: 150 mg 210 mg 300 mg 405 mg Other dose _____ mg

Was the injection given in gluteal muscle? Yes No

Height:
 (inches)
 Weight:
 (lbs.)

PDSS SIGNS AND SYMPTOMS

Please mark the signs and symptoms that the patient experienced (check all that apply)

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Aggressiveness | <input type="checkbox"/> Coma | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Tachycardia |
| <input type="checkbox"/> Agitation | <input type="checkbox"/> Confusion | <input type="checkbox"/> Hypotension | <input type="checkbox"/> Various extrapyramidal symptoms |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Convulsion/Seizure | <input type="checkbox"/> Other cognitive impairment | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Aspiration | <input type="checkbox"/> Delirium | <input type="checkbox"/> Possible neuroleptic malignant syndrome | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Ataxia | <input type="checkbox"/> Disorientation | <input type="checkbox"/> Reduced level of consciousness | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cardiac arrhythmias | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Respiratory depression | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cardiopulmonary arrest | <input type="checkbox"/> Dysarthria | <input type="checkbox"/> Sedation | <input type="checkbox"/> Other _____ |

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POST INJECTION DELIRIUM/SEDATION SYNDROME (PDSS) FORM

PDSS
Page 2 of 3

Patient No.: (PIN)

Patient Name: _____
First Name MI Last Name

PDSS start date: - -
month day year

PDSS resolution date: - - OR Ongoing
month day year

If resolved, duration of PDSS: _____ Minutes Hours Days

Are these PDSS symptoms related to ZYPREXA RELPREVV?

Yes
 No - Please Explain _____

Describe the clinical course _____

Patient Outcome: (choose one) Recovered Fatal Not Recovered
 Unknown Recovering Recovered with sequelae

Once a PDSS event was suspected, was the patient's monitoring initiated in a facility capable of resuscitation?
 Yes No

Did the patient visit the emergency room as a result of the PDSS? Yes No

Was the patient admitted to the hospital as a result of the PDSS? Yes No

Were olanzapine concentrations collected? Yes No

Did the patient receive any **MEDICATIONS AS TREATMENT** for the PDSS event?

Yes - Please record below No

Treatment Medication Name	Dose	Duration of Use (in Days)



