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 prescr ber 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 prescr ber 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): [______________________]

Phone 1-877-772-9390  FAX 1-877-772-9391  www.zyprexarelprevvprogram.com