MULTIPLE PATIENT INJECTION FORM

INJECTION Multiple Patients

ZYPREXA Relprevv (olanzapine) For Extended Release Injectable Suspension

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 injection. If you are aware that the patient's prescriber has changed, please notify the ZYPREXA RELPREVV Patient Care Program Coordinating Center.

Injection Facility Name: _____

Date of Injection ☐☐-☐☐-☐☐☐☐ (month – day – year)

	Patient Info.	Patient Info.	Patient Info.
Patient No.: (PIN)	☐☐☐☐☐☐	☐☐☐☐☐☐	☐☐☐☐☐☐
Patient Name:	First Name MI Last Name	First Name MI Last Name	First Name MI Last Name
Date of Birth:	___-___-___ month day year	___-___-___ month day year	___-___-___ month day year
PDSS since last visit? (check one)	☐ Yes ☐ No If Yes, has the prescriber been notified of the PDSS event? ☐ Yes ☐ No	☐ Yes ☐ No If Yes, has the prescriber been notified of the PDSS event? ☐ Yes ☐ No	☐ Yes ☐ No If Yes, has the prescriber been notified of the PDSS event? ☐ Yes ☐ No
Time of Injection (24-hour clock)	☐☐ : ☐☐	☐☐ : ☐☐	☐☐ : ☐☐
Dose of Injection (check one)	☐ 150 mg ☐ 210 mg ☐ 300 mg ☐ 405 mg ☐ Other dose _____ mg	☐ 150 mg ☐ 210 mg ☐ 300 mg ☐ 405 mg ☐ Other dose _____ mg	☐ 150 mg ☐ 210 mg ☐ 300 mg ☐ 405 mg ☐ Other dose _____ mg
Observed at least 3 hours post-injection? (check one)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
PDSS during onsite observation? (check one)	☐ Yes ☐ No If Yes, has the prescriber been notified of the PDSS event? ☐ Yes ☐ No	☐ Yes ☐ No If Yes, has the prescriber been notified of the PDSS event? ☐ Yes ☐ No	☐ Yes ☐ No 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? (check one)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Following the injection, was the patient accompanied from the facility? (check one)	☐ Yes ☐ No ☐ Not applicable, patient did not leave facility (in-patient)	☐ Yes ☐ No ☐ Not applicable, patient did not leave facility (in-patient)	☐ Yes ☐ No ☐ Not applicable, patient did not leave facility (in-patient)
Signature	Healthcare Facility Staff Member Signature ☐☐-☐☐-☐☐☐☐ month day year Healthcare Facility Staff Member Name (print)	Healthcare Facility Staff Member Signature ☐☐-☐☐-☐☐☐☐ month day year Healthcare Facility Staff Member Name (print)	Healthcare Facility Staff Member Signature ☐☐-☐☐-☐☐☐☐ month day year Healthcare Facility Staff Member Name (print)
Was the patient or legal guardian given a Medication Guide prior to this injection?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

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