POST INJECTION DELIRIUM/SEDATION SYNDROME (PDSS) FORM

PDSS
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Zyprexa Relprevv (olanzapine) For Extended Release Injectable Suspension

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

Time of ZYPREXA RELPREVV Injection: ☐☐:☐☐
24-hour clock

Convenience Kit Package

Lot #_____

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

- ☐ 1 - 15 minutes
- ☐ 16 - 30 minutes
- ☐ 31 - 45 minutes
- ☐ 46 - 60 minutes
- ☐ 61 - 90 minutes (1 ½ hours)
- ☐ 91 - 120 minutes (2 hours)
- ☐ 121 - 150 minutes (2 ½ hours)
- ☐ 151 - 180 minutes (3 hours)
- ☐ 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)

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

PHONE 1 877 772 9390 **FAX 1 877 772 9391** **www.zprexarelprevvprogram.com**

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POST INJECTION DELIRIUM/SEDATION SYNDROME (PDSS) FORM

Patient No.: (PIN) ☐☐☐☐☐☐

Patient Name: _____ _____ _____
First Name MI Last Name

PDSS start date: ☐☐-☐☐-☐☐☐☐ (month-day-year)

PDSS resolution date: ☐☐-☐☐-☐☐☐☐ (month-day-year) OR ☐ Ongoing

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)

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Patient No.: ☐☐☐☐☐☐
(PIN)
Patient Name: _____ _____ _____
First Name MI Last Name

Did the patient receive any **NON-PHARMACEUTICAL TREATMENTS or DIAGNOSTIC TESTS** associated with this event? ☐ Yes - Please record below ☐ No

☐ Assisted ventilation
☐ Brain CT
☐ ECG
☐ EEG
☐ IV fluids
☐ Labs
☐ MRI
☐ Observation/symptomatic management
☐ Restraints
☐ Urine drug screen
☐ Vital sign monitoring
☐ Other _____

Please fax test results to 1-877-772-9391.

HISTORY PRIOR TO PDSS EVENT

Does the patient have any relevant comorbidities?

☐ Yes - Please specify: _____

☐ No

PRIOR MEDICATIONS

Did the patient take any medications during the 24 hours prior to the injection? ☐ Yes - Please record below ☐ No

Prior Medication Name	Dose	Duration of Use	
		Number	Choose One
			☐ Days ☐ Months ☐ Years
			☐ Days ☐ Months ☐ Years
			☐ Days ☐ Months ☐ Years
			☐ Days ☐ Months ☐ Years
			☐ Days ☐ Months ☐ Years

Did the patient use any of the following during the 24 hours prior to the injection? ☐ Yes - Please record below ☐ No

☐ Alcohol
☐ Amphetamines/Methamphetamines
☐ Barbiturates
☐ Cannabinoid
☐ Cocaine
☐ Hallucinogens
☐ Opiates
☐ Phencyclidine

Event reported by: _____ _____ _____
First MI Last

Title/Occupation: _____

If agent of the Prescriber, name of Prescriber: _____ _____ _____
First MI Last

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