From pharmacists, we expect, in particular, information on drugs in the bold square on the back side (Pharmacists) pink

Please check age (on the first prescription date) and sex below and amend them if any error is found.

Japanese version of PEM

Prescription-Event Monitoring (PEM)

To Pharmacists in hospital pharmacies

・Please answer to the questions regarding the patient prescribed the drug, ○○○○○○○○○○.

Patient Code: △△△△△△△△△△

Sex: ◆

Age: ◆◆ (on the date of the first prescription, / /199○)

This questionnaire is designed to collect events.

・ What is event？

'Event' is defined as: Patient's complaint on any symptoms or sign (if diagnosis is known from the patient, describe it), any reason for a referral to a new hospital or admission to hospital, any drug reaction suspected by doctor or pharmacist, or any other complaint which was considered of sufficient importance to enter into patient's notes which occurred after the use of ○○○○○○○○.

・Example of events: Peptic ulcer, heart burn, anxiety, tachycardia, liver funciton abnormality, admission to a hospital due to broken leg etc'.

＃Diagnosis obtained by asking the patient. If it is uncertain please describe sign, symptom, or complaint by using patient's own words. Please leave the cell open if you have not asked the patient but do not guess the diagnosis.

Date patient started ○○○○○○○○○○:

/ / (first prescription date, FPD▲)

On FPD the patient was: a in hospital b ambulatory c unknown

Reason for prescription (Diagnosis etc.)＃:

Date when it developed for the first time: /

Date when drug treatment started: /

Concurrent diseases＃:

Current state of the patient:

a in hospital b ambularoty c seen by another doctor

d treatment finished e disappeared during treatment

f patient deceased

In case c-f

Last date when you saw the patient or DOD: / /

Its reason:

Events which have occurred after the first prescription date(▲) ※Definition of event is given above

Date	Events while taking ○○○○○○○○※	Date	Events after stopping ○○○○○○○※
/ /		/ /	
/ /		/ /	
/ /		/ /	
/ /		/ /	
/ /		/ /	
/ /		/ /	
/ /		/ /	

※If you judge that the event is likely to be an ADR to any drug used (where the probablity that the event is an ADR exceeds the probablity that it is not), add "(probably) an ADR to ---". In addtion, if that event has been reported to a drug compny or MHW etc., please add "reported to MHW (or the name of the drug company) as an ADR".

Hospital Name:

Address:

Telephone number:

Facsimile number:

Pharmacist's name:

Date: / /

(裏面へつづく)

Dose of ○○○○○○ and patient's compliance

Patient's compliance:

a taking the drug as indicated b taking the drug almost as indicated c often not taking the drug d taking little or no drugs prescribed e don't know

Reason for poor compliance in case b-d:

Duration while the patient used ○○○○○○ and daily dose:
(not date of dispensiing the drug)

/ / ～ / / mg/day ☐
/ / ～ / / mg/day ☐
/ / ～ / / mg/day ☐
/ / ～ / / mg/day ☐

Enter X into☐ if the drug was temporarily stopped after the duration ↑

Current state for the administration of ○○○○○○: (If the patient is not ambulatory nor in hospital, please give the information at the time of the last vist or that on DOD)

a Patient still continues to use the drug

b Substituted by other drug Date when substituted: / / Name of Drug(s) substituted:
Reason for substituting other drug:

c Drug has been stopped without substitution Date patient stopped this drug: / /
Reason for stopping this drug:

Drug with the same indication added while the patient is treated with ○○○○○○

Yes No Don't know Date when added: / / Name of Drug(s) added:

Reason for the adding the drug:

concomittant drugs (Plese indicate 'nothing' or 'don't know' if applicable)

Concurrent drugs used around when the first prescription date (▲ on the top side) or thereafter (mention the drugs already given above as drugs substituted or added as well other antihypertensives and drugs other than antihypertensives including OTC drugs) [you may attach print out from computer]

Duration☆	Drug Name	Dose★
		/
		/
		/
		/
		/
		/
		/

☆(Ex) 1997/1/4～3/10 , 8/4～10/2
or 1997/ 3/ 5 PRN #10

★mg/day
or mg PO

Does the patient receive any drug in other hospital(s)?

Yes No Don't know

If yes, does the above description include the drugs prescribed in other hospital(s) ?

All of them included Some included Don't know Nothing included

Date when the questionnaire is passed to doctor regarding this patient: / /

Thank you very much

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Address
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