Short Data Form

< Inclusion Criterion >

Patients with diagnosis of schizophrenia on the day of survey will be included.

(Both inpatient and outpatient)

< Target Dates >

1st to 31st March, 2016

This form is to be completed by a physician in charge of the patient.

Information about the collaborator

Serial number: (Automatically generated)

Patient No: ____ ____ ____ ____

(Please count at each physician's level from the number one)

Patient ID: ____

Date of Survey: ____ , March, 2016 (Date of Prescribed)

Prescribing psychiatrist name

first name: ____

middle name: ____

last name: ____

Prescribing psychiatrist: ☐1.Resident ☐2.Attending(____ years practice)

Patient: ○1.Inpatient ○2.Outpatient

Next(save)

A) PATIENT'S PROFILE

1. **Age:** years
2. **Weight:** kg; **Height:** cm; **BMI:**
3. **Sex:** 1.Male 2.Female
4. **for inpatient :**
   Date of the current admission (y/m/d): / /
   First admission: 1.Yes 2.No ; if No, number of current admission:
5. **for outpatient :**
   Date of the initiating the current treatment (y/m/d): / /
   First treatment: 1.Yes 2.No ; if No, 3.Readmission 4.Others
6. **Duration from the onset until now:**
   - 1. Less than 3 months
   - 2. 3 - 6 months
   - 3. 6 months - 1 year
   - 4. 1 year - Less than 5 years
   - 5. 5 year - Less than 10 years
   - 6. 10 year - Less than 20 years
   - 7. More than 20 years

B) DIAGNOSIS

7. **Diagnosis of Schizophrenia was based on which criteria (please choose ONLY 1)**
   - 1. ICD (coding No.)
   - 2. DSM
   - 3. National Criteria(e.g.,CCMD) (coding No.)
   - 4. Other ( )

C) COURSE

8. **Course of illness for the past 1 year (both for inpatients and outpatients)**
   - 1. Remission
   - 2. Continuing presence of symptoms

D) CURRENT SYMPTOMS

9. Significant symptoms for the past 1 month are (plural choice):

- [ ] 1.Delusions
- [ ] 2.Hallucinations
- [ ] 3.Disorganized speech, e.g. frequent derailment or incoherence
- [ ] 4.Grossly disorganized or cataonic behavior
- [ ] 5.Negative symptoms, e.g. affective flattening, alogia, or avolition
- [ ] 6.Existence of social/occupational dysfunction
- [ ] 7.Verbal aggression
- [ ] 8.Physical aggression
- [ ] 9.Significant affective symptoms
- [ ] 10.Other symptoms (Please specify: ____)

Next(save)

E) PRESCRIPTION (including all medications on the day of survey)

10. Depot injections ○1.Yes ○2.No

If yes,please key in as prescribed, any depot injections given within past 1 month

(Frequency: q1w = every once a week; q2w = once every two weeks; q1m = once a month; ...)

Drug name/unit	**doses**	**Frequency** Ex:(q1w, q2w or q1m)	**Total dosage per 1 month**	**Action**
e.g. Fluanxol depot(flupentixol) 20mg/1ml/amp	20	q2w	40mg	
				Delete
				Delete
+				

11. Psychotropic medications ○1.Yes ○2.No

If yes, please key in as prescribed, all psychotropic medications on the day of survey, within 24 hours, from 6am to 6am

(Frequency: bid = 2 times a day, morning and evening; qid = 4 times daily; hs = 1 times a day, at bedtime; ...)

Drug name	**unit** (mg/tab)	**doses**	**Frequency** Ex:(bid, qid, hs...)	**Total dosage per day**	**Action**
e.g. Haloperidol	2	1	tid	6mg	
e.g. Trihexyphenidyl	2	1	bid	4mg	
					Delete
					Delete
+					

12. Other medications ○1.Yes ○2.No

If yes, please key in as prescribed, all other medications on the day of survey, within 24 hours, from 6am to 6am

(Frequency: bid = 2 times a day, morning and evening; qid = 4 times daily; hs = 1 times a day, at bedtime; ...)

Drug name	**unit** (mg)	**doses**	**Frequency** Ex:(bid, qid, hs...)	**Total dosage per day**	**Action**
e.g. Amilodipine	5	1	qd	5mg	
e.g. Avorvastatin calcium	10	1	bid	20mg	
					Delete
					Delete
					Delete
					Delete
+					

F) ECT

13. Has this patient received ECT therapy

○ 1.Yes received in the past

○ 2.Yes concurrently (in the course of this episode)

○ 0.No

Next(save)

G) REPORTED ADVERSE EVENTS

14. Evaluation based on: ☐ 1.patient's self report ☐ 2.psychiatrist's interview/observation

15. Please tick the reported symptoms of the patient on the day of survey.

("9.No information" is the choice for iten that requires patient's complaint or laboratory data).

(a)Movement disorders:

symptoms	1.Yes	0.No	9.No information	Action
1. Rigidity	○	○	○	
2. Akinesia	○	○	○	
3. Tremor	○	○	○	
4. Akathisia	○	○	○	
5. Dystonia	○	○	○	
6. Tardive dyskinesia	○	○	○	
	○	○	○	Delete
	○	○	○	Delete
	○	○	○	Delete
	○	○	○	Delete
	○	○	○	Delete
7. Other (please specified)	+			

(b)Autonomic adverse effects:

symptoms	1.Yes	0.No	9.No information	Action
1. Constipation	○	○	○	
2. Excessive salivation	○	○	○	
3. Dry month	○	○	○	
4. Postural hypotension	○	○	○	
5. Difficulty in micturition	○	○	○	
6. Blurring of vision	○	○	○	
	○	○	○	Delete
	○	○	○	Delete
	○	○	○	Delete
	○	○	○	Delete
	○	○	○	Delete
7. Other (please specified)	+			

(c)Endocrinological disturbance:

symptoms	1.Yes	0.No	9.No information	Action
1. Sexual dysfunction	○	○	○	
2. Galactorrhea, amenorrhea in women or gynecomastia in men	○	○	○	
	○	○	○	Delete
	○	○	○	Delete
	○	○	○	Delete
	○	○	○	Delete
	○	○	○	Delete
3. Other (please specified)	+			

(d)Metabolic dysfunction(within the past 3months):

symptoms	1.Yes	0.No	9.No information	Action
1. Impaired glucose tolerance (hyperglycaemia, diabetes mellitus, diabetic ketoacidosis)	○	○	○	
2. Hypercholesterolemia	○	○	○	
3. Weight gain If yes, from baseline from [ ] kg to [ ] kg, in [ ] months	○	○	○	
[ ]	○	○	○	Delete
[ ]	○	○	○	Delete
4. Other (please specified)	+			

(e)Cardiovascular adverse effect(within the past3 months):

symptoms	1.Yes	0.No	9.No information	Action
1. QTc-interval lengthening (QTc > 456ms)	○	○	○	
[ ]	○	○	○	Delete
[ ]	○	○	○	Delete
2. Other (please specified)	+			

(f)Others:

symptoms	1.Yes	0.No	9.No information	Action
1. Over sedation (drowsy most of day)	○	○	○	
[ ]	○	○	○	Delete
[ ]	○	○	○	Delete
2. Other (please specified)	+			

If you are OK, than enter save