

General interview on psychotropic medication

1. 1.1. What is the reason for the prescription?

Please enter the name of the psychotropic medication:

Please state reason for prescription

1.....	<input type="checkbox"/> _9	unknown
2.....	<input type="checkbox"/> _9	unknown
3.....	<input type="checkbox"/> _9	unknown
4.....	<input type="checkbox"/> _9	unknown

Please enter the name of the psychotropic medication:

1. 2. 3. 4. 5.

Please assign:

1.2. mental disorder	<input type="checkbox"/> _01	<input type="checkbox"/> _01	<input type="checkbox"/> _01	<input type="checkbox"/> _01	<input type="checkbox"/> _01
1.3. challenging behaviour	<input type="checkbox"/> _01	<input type="checkbox"/> _01	<input type="checkbox"/> _01	<input type="checkbox"/> _01	<input type="checkbox"/> _01
1.4. target symptom	<input type="checkbox"/> _01	<input type="checkbox"/> _01	<input type="checkbox"/> _01	<input type="checkbox"/> _01	<input type="checkbox"/> _01
1.5. neurological disorder	<input type="checkbox"/> _01	<input type="checkbox"/> _01	<input type="checkbox"/> _01	<input type="checkbox"/> _01	<input type="checkbox"/> _01
1.6. side effects	<input type="checkbox"/> _01	<input type="checkbox"/> _01	<input type="checkbox"/> _01	<input type="checkbox"/> _01	<input type="checkbox"/> _01
1.7. other	<input type="checkbox"/> _01	<input type="checkbox"/> _01	<input type="checkbox"/> _01	<input type="checkbox"/> _01	<input type="checkbox"/> _01
unknown	<input type="checkbox"/> _9	<input type="checkbox"/> _9	<input type="checkbox"/> _9	<input type="checkbox"/> _9	<input type="checkbox"/> _9

1.2.1. If prescribed due to a mental disorder, please indicate ICD-10 number:

ICD-10 number
unknown	<input type="checkbox"/> _9	<input type="checkbox"/> _9	<input type="checkbox"/> _9	<input type="checkbox"/> _9	<input type="checkbox"/> _9

If prescribed due to challenging behaviour, please assign: *(multiple selection possible)*

1.3.1. verbally aggressive behaviour	<input type="checkbox"/> _01	<input type="checkbox"/> _01	<input type="checkbox"/> _01	<input type="checkbox"/> _01	<input type="checkbox"/> _01
1.3.2. physically aggressive behaviour	<input type="checkbox"/> _02	<input type="checkbox"/> _02	<input type="checkbox"/> _02	<input type="checkbox"/> _02	<input type="checkbox"/> _02
1.3.3. destructive behaviour (destructive rage)	<input type="checkbox"/> _03	<input type="checkbox"/> _03	<input type="checkbox"/> _03	<input type="checkbox"/> _03	<input type="checkbox"/> _03
1.3.4. self-injurious behaviour	<input type="checkbox"/> _04	<input type="checkbox"/> _04	<input type="checkbox"/> _04	<input type="checkbox"/> _04	<input type="checkbox"/> _04
1.3.5. inappropriate sexual behaviour	<input type="checkbox"/> _05	<input type="checkbox"/> _05	<input type="checkbox"/> _05	<input type="checkbox"/> _05	<input type="checkbox"/> _05
1.3.6. disturbance of social behaviour with oppositional, defiant behaviour	<input type="checkbox"/> _06	<input type="checkbox"/> _06	<input type="checkbox"/> _06	<input type="checkbox"/> _06	<input type="checkbox"/> _06

<i>Please enter the name of the psychotropic medication:</i>	1.	2.	3.	4.	5.
1.3.7. excessively demanding behaviour	<input type="checkbox"/> ₀₇	<input type="checkbox"/> ₀₇	<input type="checkbox"/> ₀₇	<input type="checkbox"/> ₀₇	<input type="checkbox"/> ₀₇
1.3.8. elopement	<input type="checkbox"/> ₀₈	<input type="checkbox"/> ₀₈	<input type="checkbox"/> ₀₈	<input type="checkbox"/> ₀₈	<input type="checkbox"/> ₀₈
1.3.9. other	<input type="checkbox"/> ₀₉	<input type="checkbox"/> ₀₉	<input type="checkbox"/> ₀₉	<input type="checkbox"/> ₀₉	<input type="checkbox"/> ₀₉
unknown	<input type="checkbox"/> . ₉	<input type="checkbox"/> . ₉	<input type="checkbox"/> . ₉	<input type="checkbox"/> . ₉	<input type="checkbox"/> . ₉
2. Is the psychotropic drug used as a mood stabilizer?					
no	<input type="checkbox"/> ₀₀	<input type="checkbox"/> ₀₀	<input type="checkbox"/> ₀₀	<input type="checkbox"/> ₀₀	<input type="checkbox"/> ₀₀
yes	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₁
unknown	<input type="checkbox"/> . ₉	<input type="checkbox"/> . ₉	<input type="checkbox"/> . ₉	<input type="checkbox"/> . ₉	<input type="checkbox"/> . ₉
3. Is medication prescribed to treat side effects?					
no	<input type="checkbox"/> ₀₀	<input type="checkbox"/> ₀₀	<input type="checkbox"/> ₀₀	<input type="checkbox"/> ₀₀	<input type="checkbox"/> ₀₀
yes	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₁
unknown	<input type="checkbox"/> . ₉	<input type="checkbox"/> . ₉	<input type="checkbox"/> . ₉	<input type="checkbox"/> . ₉	<input type="checkbox"/> . ₉
3.1. If yes: Which medication?					
Please specify medication:					
4. Who first prescribed the psychotropic medication?					
psychiatrist	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₁
psychiatrist experienced in the treatment of people with intellectual disabilities	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₂
neurologist	<input type="checkbox"/> ₀₃	<input type="checkbox"/> ₀₃	<input type="checkbox"/> ₀₃	<input type="checkbox"/> ₀₃	<input type="checkbox"/> ₀₃
specialist in psychiatry and neurology	<input type="checkbox"/> ₀₄	<input type="checkbox"/> ₀₄	<input type="checkbox"/> ₀₄	<input type="checkbox"/> ₀₄	<input type="checkbox"/> ₀₄
paediatrician	<input type="checkbox"/> ₀₅	<input type="checkbox"/> ₀₅	<input type="checkbox"/> ₀₅	<input type="checkbox"/> ₀₅	<input type="checkbox"/> ₀₅
general practitioner	<input type="checkbox"/> ₀₆	<input type="checkbox"/> ₀₆	<input type="checkbox"/> ₀₆	<input type="checkbox"/> ₀₆	<input type="checkbox"/> ₀₆
other specialist	<input type="checkbox"/> ₀₇	<input type="checkbox"/> ₀₇	<input type="checkbox"/> ₀₇	<input type="checkbox"/> ₀₇	<input type="checkbox"/> ₀₇
unknown	<input type="checkbox"/> . ₉	<input type="checkbox"/> . ₉	<input type="checkbox"/> . ₉	<input type="checkbox"/> . ₉	<input type="checkbox"/> . ₉

Please enter the name of the psychotropic medication: 1. 2. 3. 4. 5.

5. Is the prescription of a psychotropic medication 'off-label', that is outside its licensed indication?

no	<input type="checkbox"/> _00	<input type="checkbox"/> _00	<input type="checkbox"/> _00	<input type="checkbox"/> _00	<input type="checkbox"/> _00
yes	<input type="checkbox"/> _01	<input type="checkbox"/> _01	<input type="checkbox"/> _01	<input type="checkbox"/> _01	<input type="checkbox"/> _01
unknown	<input type="checkbox"/> _9	<input type="checkbox"/> _9	<input type="checkbox"/> _9	<input type="checkbox"/> _9	<input type="checkbox"/> _9

5.1. to be entered by the interviewer after comprehensive research: Is the prescription of a psychotropic medication 'off-label', that is outside its licensed indication?

no	<input type="checkbox"/> _00	<input type="checkbox"/> _00	<input type="checkbox"/> _00	<input type="checkbox"/> _00	<input type="checkbox"/> _00
yes	<input type="checkbox"/> _01	<input type="checkbox"/> _01	<input type="checkbox"/> _01	<input type="checkbox"/> _01	<input type="checkbox"/> _01
unknown	<input type="checkbox"/> _9	<input type="checkbox"/> _9	<input type="checkbox"/> _9	<input type="checkbox"/> _9	<input type="checkbox"/> _9

6. Is there a parameter monitoring (laboratory parameters, apparatus tests) of the psychotropic medication?

no	<input type="checkbox"/> _00	<input type="checkbox"/> _00	<input type="checkbox"/> _00	<input type="checkbox"/> _00	<input type="checkbox"/> _00
yes	<input type="checkbox"/> _01	<input type="checkbox"/> _01	<input type="checkbox"/> _01	<input type="checkbox"/> _01	<input type="checkbox"/> _01
not required (PRN medication)	<input type="checkbox"/> _03	<input type="checkbox"/> _03	<input type="checkbox"/> _03	<input type="checkbox"/> _03	<input type="checkbox"/> _03
unknown	<input type="checkbox"/> _9	<input type="checkbox"/> _9	<input type="checkbox"/> _9	<input type="checkbox"/> _9	<input type="checkbox"/> _9

6.1. Falls yes: By whom is the parameter monitoring performed?

psychiatrist	<input type="checkbox"/> _01	<input type="checkbox"/> _01	<input type="checkbox"/> _01	<input type="checkbox"/> _01	<input type="checkbox"/> _01
psychiatrist experienced in the treatment of people with intellectual disabilities	<input type="checkbox"/> _02	<input type="checkbox"/> _02	<input type="checkbox"/> _02	<input type="checkbox"/> _02	<input type="checkbox"/> _02
neurologist	<input type="checkbox"/> _03	<input type="checkbox"/> _03	<input type="checkbox"/> _03	<input type="checkbox"/> _03	<input type="checkbox"/> _03
paediatrician	<input type="checkbox"/> _04	<input type="checkbox"/> _04	<input type="checkbox"/> _04	<input type="checkbox"/> _04	<input type="checkbox"/> _04
specialist in psychiatry and neurology	<input type="checkbox"/> _05	<input type="checkbox"/> _05	<input type="checkbox"/> _05	<input type="checkbox"/> _05	<input type="checkbox"/> _05
general practitioner	<input type="checkbox"/> _06	<input type="checkbox"/> _06	<input type="checkbox"/> _06	<input type="checkbox"/> _06	<input type="checkbox"/> _06
other specialist	<input type="checkbox"/> _07	<input type="checkbox"/> _07	<input type="checkbox"/> _07	<input type="checkbox"/> _07	<input type="checkbox"/> _07
other non-physician person	<input type="checkbox"/> _08	<input type="checkbox"/> _08	<input type="checkbox"/> _08	<input type="checkbox"/> _08	<input type="checkbox"/> _08
unknown	<input type="checkbox"/> _9	<input type="checkbox"/> _9	<input type="checkbox"/> _9	<input type="checkbox"/> _9	<input type="checkbox"/> _9

Please enter the name of the psychotropic medication:

1. 2. 3. 4. 5.

7. Were there any dose adjustments during the last year?

dose increase	<input type="checkbox"/> _01	<input type="checkbox"/> _01	<input type="checkbox"/> _01	<input type="checkbox"/> _01	<input type="checkbox"/> _01
dose reduction	<input type="checkbox"/> _02	<input type="checkbox"/> _02	<input type="checkbox"/> _02	<input type="checkbox"/> _02	<input type="checkbox"/> _02
dose increase and reduction	<input type="checkbox"/> _03	<input type="checkbox"/> _03	<input type="checkbox"/> _03	<input type="checkbox"/> _03	<input type="checkbox"/> _03
no dose change	<input type="checkbox"/> _04	<input type="checkbox"/> _04	<input type="checkbox"/> _04	<input type="checkbox"/> _04	<input type="checkbox"/> _04
unknown	<input type="checkbox"/> _9	<input type="checkbox"/> _9	<input type="checkbox"/> _9	<input type="checkbox"/> _9	<input type="checkbox"/> _9

7.1. If there was a dose adjustment, what were the causes of the adjustment?

efficacy	<input type="checkbox"/> _01	<input type="checkbox"/> _01	<input type="checkbox"/> _01	<input type="checkbox"/> _01	<input type="checkbox"/> _01
side effects	<input type="checkbox"/> _02	<input type="checkbox"/> _02	<input type="checkbox"/> _02	<input type="checkbox"/> _02	<input type="checkbox"/> _02
efficacy and side effects	<input type="checkbox"/> _03	<input type="checkbox"/> _03	<input type="checkbox"/> _03	<input type="checkbox"/> _03	<input type="checkbox"/> _03
other	<input type="checkbox"/> _04	<input type="checkbox"/> _04	<input type="checkbox"/> _04	<input type="checkbox"/> _04	<input type="checkbox"/> _04
unknown	<input type="checkbox"/> _9	<input type="checkbox"/> _9	<input type="checkbox"/> _9	<input type="checkbox"/> _9	<input type="checkbox"/> _9
not applicable	<input type="checkbox"/> _8	<input type="checkbox"/> _8	<input type="checkbox"/> _8	<input type="checkbox"/> _8	<input type="checkbox"/> _8

7.2. If there has been a dose reduction, was it as part of a medication discontinuation process?

no	<input type="checkbox"/> _00	<input type="checkbox"/> _00	<input type="checkbox"/> _00	<input type="checkbox"/> _00	<input type="checkbox"/> _00
yes	<input type="checkbox"/> _01	<input type="checkbox"/> _01	<input type="checkbox"/> _01	<input type="checkbox"/> _01	<input type="checkbox"/> _01
unknown	<input type="checkbox"/> _9	<input type="checkbox"/> _9	<input type="checkbox"/> _9	<input type="checkbox"/> _9	<input type="checkbox"/> _9
not applicable	<input type="checkbox"/> _8	<input type="checkbox"/> _8	<input type="checkbox"/> _8	<input type="checkbox"/> _8	<input type="checkbox"/> _8

8.1. Are several regular psychotropic medications used to treat the same symptomatology mentioned above in the prescription reasons (excluding PRN medication)?

_00 no _01 yes _9 unknown

If yes, please state reason for prescription:

8.1.1.....

8.1.2.....

8.2. Are several psychotropic medications used to treat the same symptomatology mentioned above in the prescription reasons (including PRN medication)?

_00 no _01 yes _9 unknown _8 not applicable/ no PRN medication prescribed

If yes, please state reason for prescription:

8.2.1.....

8.2.2.....

9. Are there any other pharmaceuticals prescribed for the treatment of psychiatric symptoms?

₀₀ no ₀₁ yes ₋₉ unknown

9.1. If yes: Which medication?

9.2. For the treatment of which mental disorder, which problem behaviour or which target symptom?

9.1.1.....

9.2.1.....

9.1.2.....

9.2.2.....

9.3. Please assign the pharmaceuticals to the following categories:

	9.3.1.	9.3.2.	9.3.3.
high dose beta blockers (e.g. atenolol, propranol)	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₁	<input type="checkbox"/> ₀₁
opioid antagonists (e.g. naloxone, naltrexone)	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₂	<input type="checkbox"/> ₀₂
melatonin	<input type="checkbox"/> ₀₃	<input type="checkbox"/> ₀₃	<input type="checkbox"/> ₀₃
clonidine	<input type="checkbox"/> ₀₄	<input type="checkbox"/> ₀₄	<input type="checkbox"/> ₀₄
other(<i>please specify</i>)	<input type="checkbox"/> ₀₅	<input type="checkbox"/> ₀₅	<input type="checkbox"/> ₀₅
not applicable	<input type="checkbox"/> ₋₈	<input type="checkbox"/> ₋₈	<input type="checkbox"/> ₋₈