Annexure I. Questionnaire For Awareness of Drug Treatment in Patients with Schizophrenia

Patient's initials: Age: Gender:

Study ID: OPD No: Date:

Please answer the following questions by ticking one option.

1. Current Prescription Domain:

i. Do you know about the medicines that have been written on the prescription today? (a) Yes (b) No (c) Cannot say (d) Refuse to answer

If yes,

State the number of medicines: _____

Response correct/incorrect as evaluated by the investigator. If incorrect, state the discrepancy :

Name the medicines:

1.
2.
3.
4.

Response correct/ incorrect as evaluated by the investigator. If incorrect, state the discrepancy :

ii. Do you know the dosing frequency of medicines prescribed to you today? (a) Yes (b) No (c) Cannot say (d) Refuse to answer

If yes,

State the dosing frequency of each medication:

Drug 1:
Drug 2:
Drug 3:
Drug 4:

Response correct/ incorrect as evaluated by the investigator. If incorrect, state the discrepancy:

iii) Do you know the reason for which you have been given each of these medicines? (a) Yes (b) No (c) Cannot say (d) Refuse to answer

If yes, state the reasons

Drug 1:
Drug 2:
Drug 3:
Drug 4:

Response correct/ incorrect as evaluated by the investigator. If incorrect, state the discrepancy:

2. Influence of Disease Severity, Concomitant Disease/Drug Awareness:

iv. Do drugs and their doses depend on:

Severity of disease	(a) Yes (b) No (c) Cannot say (d) Refuse to answer
Response to treatment	(a) Yes (b) No (c) Cannot say (d) Refuse to answer
Presence of other illnesses	(a) Yes (b) No (c) Cannot say (d) Refuse to answer
Intake of concurrent medications	(a) Yes (b) No (c) Cannot say (d) Refuse to answer

3. Drug Compliance Awareness:

v. Is it important to follow a dosing schedule? (a) Yes (b) No (c) Cannot say (d) Refuse to answer

vi. Do you skip your medication dose often? (a) Yes (b) No (c) Cannot say (d) Refuse to answer

If yes,

State the reason for skipping medicine dose : _____

vii. Do you know what to do if you skip a medication dose? (a) Yes (b) No (c) Cannot say (d) Refuse to answer

If yes, state: _____

Response correct/ incorrect as evaluated by the investigator. If incorrect, state the discrepancy :

viii. Have you ever stopped taking medicines for your illness on a continuous basis (for more than 3 days) against the doctor's advice? (a) Yes (b) No (c) Cannot say (d) Refuse to answer

If yes,

State the reason for stopping medications: _____

4. Past Medication Record Awareness:

ix. Do you maintain a record of the past medication prescriptions? (a) Yes (b) No (c) Cannot say (d) Refuse to answer

Response correct/ incorrect as evaluated by the investigator. If incorrect, state the discrepancy :

5. Re-visit/Re-Contact Instruction Awareness:

x. Do you know when is your next follow up? (a) Yes (b) No (c) Cannot say (d) Refuse to answer

If yes, state: _____

Response correct/ incorrect as evaluated by the investigator. If incorrect, state the discrepancy :

xi. Is it important to keep a a regular follow-up with the consulting physician? (a) Yes (b) No (c) Cannot say (d) Refuse to answer

xii. Is it important to consult your doctor before taking any concurrent medications? (a) Yes (b) No (c) Cannot say (d) Refuse to answer

6. Side Effects Awareness:

xiii. Can drugs given to you cause undesired effects (side effects)? (a) Yes (b) No (c) Cannot say (d) Refuse to answer

If yes, please tick the side effect that you are aware of:

xiv. If you experience side effects, will you report the side effects to your doctor? (a) Yes (b) No (c) Cannot say (d) Refuse to answer

		Headache
		Difficulty in falling asleep/ Increased duration of sleep/ Decreased duration of sleep
		Skin rash/ Itching
		Dry mouth
		Blurred vision
		Urination difficulty
		Constipation
		Vomiting
		Uncontrolled movements in eyes/tongue/jaw/neck
		Tremors
		Restlessness or jitteriness
		Muscle stiffness
		Fever
		Sweating
		Increase in breast size
		Irregular menses
		Weight gain
		Drowsiness
		Difficulty in intercourse
		Seizures
		Palpitations
		Yellow discoloration of skin and eyes
		Black tarry stools
		Breathing difficulty
		Stuffy nose
		Sore throat
		Unusual bleeding
		Confusion
		Muscle pain
		Weakness
		Appetite changes

xv. Do you know that you may need separate treatment to manage the (a) Yes (b) No (c) Cannot say (d) Refuse to answer

side effects?

7. Long-term Treatment Awareness:

xvi. Do you know that you may need to take medications for a long term? (a) Yes (b) No (c) Cannot say (d) Refuse to answer

Annexure II. Questionnaire for Awareness of Drug Treatment in Caregivers of Patients with Schizophrenia

Caregiver's initials: Age: Gender:

Relationship with the patient: Study ID: Date:

Please answer the following questions by ticking one option

1. Current Prescription Domain:

i. Do you know about the medicines that have been written on patient's prescription today? (a) Yes (b) No (c) Cannot say (d) Refuse to answer

If yes,

State the number of medicines: _____

Response correct/ incorrect as evaluated by the investigator. If incorrect, state the discrepancy :

Name the medicines:

1.
2.
3.
4.

Response correct/ incorrect as evaluated by the investigator. If incorrect, state the discrepancy :

ii. Do you know the reason for which (a) Yes (b) No (c) Cannot say (d) Refuse to answer

patient has been given each of these medicines?

If yes, state the reasons

Drug 1:
Drug 2:
Drug 3:
Drug 4:

Response correct/ incorrect as evaluated by the investigator. If incorrect, state the discrepancy :

iii. Do you know the dosing frequency of medicines prescribed to the patient today ? (a) Yes (b) No (c) Cannot say (d) Refuse to answer

If yes,

State the dosing frequency of each medication:

Drug 1:
Drug 2:
Drug 3:
Drug 4:

Response correct/ incorrect as evaluated by the investigator. If incorrect, state the discrepancy:

2. Influence of Disease Severity, Concomitant Disease/Drug Awareness:

iv. Do drugs and their doses depend on:

Severity of disease (a) Yes (b) No (c) Cannot say (d) Refuse to answer

Response to treatment (a) Yes (b) No (c) Cannot say (d) Refuse to answer

Accompanying comorbid diseases (a) Yes (b) No (c) Cannot say (d) Refuse to answer

Intake of concurrent medications (a) Yes (b) No (c) Cannot say (d) Refuse to answer

3. Drug Compliance Awareness:

v. Is it important for the patient to follow a dosing schedule? (a) Yes (b) No (c) Cannot say (d) Refuse to answer

vi. Does the patient skip his medicine dose often? (a) Yes (b) No (c) Cannot say (d) Refuse to answer

If yes,

State the reason for skipping medicines : _____

vii. Do you know what to do if the patient skips a medication dose?

If yes, state: _____

Response correct/ incorrect as evaluated by the investigator. If incorrect, state the discrepancy :

viii. Has the patient ever stopped taking medicines for his illness on a continuous basis (for more than three days) against the doctors' advice? (a) Yes (b) No (c) Cannot say (d) Refuse to answer

If yes,

State the reason for stopping medications: _____

4. Past Medication Record Awareness:

ix. Is the record of the patient's past medication prescriptions maintained? (a) Yes (b) No (c) Cannot say (d) Refuse to answer

Response correct/ incorrect as evaluated by the investigator. If incorrect, state the discrepancy :

5. Re-Visit/Re-Contact Instruction Awareness:

x. Do you know when is the patient's next follow-up? (a) Yes (b) No (c) Cannot say (d) Refuse to answer

If yes, state : _____

Response correct/ incorrect as evaluated by the investigator. If incorrect, state the discrepancy :

xi. Is it important for the patient to keep a regular follow-up with the consulting physician? (a) Yes (b) No (c) Cannot say (d) Refuse to answer

xii. Is it important for the patient to consult doctor before taking any concurrent medications? (a) Yes (b) No (c) Cannot say (d) Refuse to answer

6. Side Effects Awareness:

xiii. Can drugs given to the patient cause undesired effects (side effects) ? (a) Yes (b) No (c) Cannot say (d) Refuse to answer

If yes, please tick the side effect that you are aware of :

	Headache
	Difficulty in falling asleep/ Increased duration of sleep/ Decreased duration of sleep
	Skin rash/ Itching
	Dry mouth
	Blurred vision
	Urination difficulty
	Constipation
	Vomiting
	Uncontrolled movements in eyes/ tongue/ jaw/ neck
	Tremors
	Restlessness or jitteriness
	Muscle stiffness
	Fever
	Sweating
	Increase in breast size
	Irregular menses
	Weight gain
	Drowsiness
	Difficulty in intercourse
	Seizures
	Palpitations
	Yellow discoloration of skin and eyes
	Black tarry stools
	Breathing difficulty
	Stuffy nose
	Sore throat
	Unusual bleeding

	Confusion
	Muscle pain
	Weakness
	Appetite changes

xiv. If the patient experiences side effects, will you report the side effects to the doctor? (a) Yes (b) No (c) Cannot say (d) Refuse to answer

xv. Do you know that patient may need separate treatment to manage the side effects? (a) Yes (b) No (c) Cannot say (d) Refuse to answer

7. Long-term Treatment Awareness:

xvi. Do you know that patient may need to take medications for a long term? (a) Yes (b) No (c) Cannot say (d) Refuse to answer