Attachment 1 - Suspected adverse event/experience from deprescribing form

**Date**

**Patient name & DOB**

**Medication/s reduced or ceased |Date reduced or ceased | Reason for deprescribing**

**Description of patient adverse effect/experience, including time in relation to medication changes** *(please be as detailed as possible)*

**Action taken to manage the adverse effect/experience**

**Clinical outcome** *(for each subheading below please delete the response/s that do not apply)*

***Current status:* (Recovered [date] | Not yet recovered | Other)**

***Seriousness of the effect/experience*: (Life threatening | Hospitalised | Required visit to doctor | Other (e.g. Phone call)**

**Attribution to deprescribing**

**In your expert opinion, do you feel that this adverse effect/experience was in any way related to deprescribing?**

***Yes / No (****If yes, please provide as much detail as possible)*

***Please contact <study co-ordinator> – via email <provided> or via mobile <provided> upon completion. Please contact co-ordinator urgently in the case of any event which was life-threatening or led to hospitalisation.***