Efficacy of Neuromuscular Blocking Drugs Information Collection Form

COMPANY REFERENCE NUMBER:		
1. REPORTER'S DETAILS	**2. PATIENT'S DETAILS**	
Name: _____ Role: _____ Address: _____ _____	Initials: _____ Age: _____ or Date of Birth: _____/_____/_____	☐ Male ☐ Female Weight _____kg Height _____cm

3a. Neuromuscular Blocking Agent administered (*please detail each dose or measurement on a new line*)

Date	Time	Train of Four Ratio	Neuromuscular blocking agent	Batch Number	Dose given (mg/kg) / infusion rate	Indication (e.g. normal / rapid sequence induction)

3b. Has the above product been consistently stored in line with section 6.4 of the SmPC?	○ Yes ○ NI ○ No (provide details)
3c. Was Train Of Four (TOF) monitoring undertaken?	○ No ○ NI ○ Yes (provide details)
3d. If TOF monitoring was NOT undertaken, please provide details of how the degree of relaxation was assessed.	

To enable this report to be investigated **fully** please ensure that **all** fields are **completed** or select **NI** where No Information is available.

4a. Please provide details of the procedure that the patient underwent

4b. If any of the below procedural complications occurred (*) please provide additional details.

Was the procedure completed successfully?	○ Yes	○ No *	○ NI
Was intubation of the patient successful?	○ Yes	○ No *	○ NI
Was extubation (and return to spontaneous breathing) of the patient successful?	○ Yes	○ No *	○ NI
Was any residual curarisation or recurarisation observed?	○ Yes *	○ No	○ NI
Were any other adverse events observed?	○ Yes *	○ No	○ NI
- Is the patient considered to be recovered from these events?	○ Yes	○ No *	○ NI
Was the patient's hospitalisation prolonged or further treatment needed?	○ Yes *	○ No	○ NI

Further details:

4c. Concomitant medication given as part of the anaesthesia protocol and surgical procedure

Time	Drug name	Indication	Dose or Rate of administration	Route of administration

4d. Reversal agents administered

Time	Drug name	Indication	Dose or Rate of administration	Route of administration

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5a. Please confirm the following medical history for the patient and where confirmed (*) provide additional details below.			
Muscle disorders (e.g. myasthenia gravis)	Yes *	No	NI
Cardiovascular disease	Yes *	No	NI
Neurological disorders (e.g. motor neurone disease)	Yes *	No	NI
Liver disorders	Yes *	No	NI
Kidney disorders	Yes *	No	NI
Severe burns to skin or inhalation burns	Yes *	No	NI
Is the patient a smoker?	Yes *	No	NI
Any other relevant medical history	Yes *	No	NI
Further details:			

5b. Please confirm ALL concomitant medication taken by the patient within the LAST 6 MONTHS and where confirmed provide additional details below.			
Corticosteroids	Yes *	No	NI
Antibiotics (e.g. aminoglycosides, lincosamides, tetracyclines, polymyxins, acylamino-penicillins, metronidazole)	Yes *	No	NI
Anticonvulsants (e.g. phenytoin, carbamazepine)	Yes *	No	NI
Phosphodiesterase inhibitors (e.g. theophylline)	Yes *	No	NI
Calcium channel blockers	Yes *	No	NI
β-blockers (e.g. propranolol)	Yes *	No	NI
Anti-arrhythmic agents (e.g. lidocaine, procainamide, quinidine)	Yes *	No	NI
Diuretics (thiazide diuretics, furosemide, mannitol)	Yes *	No	NI
Local anaesthetics including via epidural route of admin (e.g. lidocaine, bupivacaine)	Yes *	No	NI
Halogenated inhalational anaesthetics (e.g. sevoflurane)	Yes *	No	NI
Drugs containing calcium, magnesium, potassium or lithium salts.	Yes *	No	NI
Any other concomitant medication	Yes *	No	NI

Please provide additional detail for any concomitant medication where Yes* was indicated above:

Drug name	Indication	Date started	Date stopped	Total Daily Dose	Route

To enable this report to be investigated **fully** please ensure that **all** fields are **completed** or select **NI** where No Information is available.