DREAMS SIDE EFFECTS

Has the patient had any of the following **in the past three months**? Please circle the appropriate answer and if the answer is **YES**, circle one of:

Mild: intervention not indicated

Moderate: intervention indicated

Severe: needs hospitalisation

1. Falls (P_SE1_B)

YES ☐ NO ☐

If YES (P_SE1s_B): Mild ☐ Moderate ☐ Severe ☐

2. Other comorbid physical illnesses

2a. Gastrointestinal (diarrhoea, nausea, sore mouth, vomiting) (P_SE2a_B)

YES ☐ NO ☐

If YES (P_SE2as_B): Mild ☐ Moderate ☐ Severe ☐

2b. Neurological (headache,visual/auditory disturbances, dizziness) (P_SE2b_B)

YES ☐ NO ☐

If YES (P_SE2bs_B): Mild ☐ Moderate ☐ Severe ☐

2c. Infections (P_SE2c_B)

YES ☐ NO ☐

If YES (P_SE2cs_B): Mild ☐ Moderate ☐ Severe ☐

2d. Has the patient developed any other side effects? (P_SE2d_B) YES ☐ NO ☐

If YES, what were these side-effects:_____
_____

_____

Any further comments_____
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