

INHALERS

INH

Patient ID: 1
 Patient Initials: _____
 Visit Number: _____
 Current Date: ____/____/____
 month day year
 Interviewer ID: _____

(Clinic Coordinator completed)


This form must be completed at each visit and between visits when a new canister is distributed.

- 01** 1. Is this a scheduled visit? ₁ Yes ₀ No
- 02** 2. If **No**, please indicate type of inhaler(s) distributed. ₁ **rescue** inhaler only
₂ **scheduled** inhaler only (V4 - V9)
₃ **both** inhalers

RESCUE INHALERS

- 03** 3. Is there an "old" canister to be weighed? ₁ Yes ₀ No
- 03A** If **No**, why not? ₁ Visit 1
₂ "old" canister was lost
₃ other
- 03B** If **Yes**, provide weight. (*canister only*) _____ g
- 04** 4. Is there a "new" canister to be weighed? ₁ Yes ₀ No
- 04A** If **No**, why not? ₁ Visit 12
₂ "old" canister is being re-used
₃ other
- 04B** If **Yes**, provide weight. (*canister only*) _____ g

SCHEDULED INHALER (Visit 4 - Visit 9)

DLN Affix and sign drug label below:


By signing the label here you are confirming that you have

- 1) checked the label on the new canister with the drug packet number on the outside of the packet and
- 2) confirmed that the drug is being given to the patient with the name and ID number written on the packet.