PATIENTS' ATTITUDES AND OPINIONS ON DEPRESCRIBING QUESTIONNAIRE

1. DATE OF BIRTH

2. SEX

☐ male ☐ female

3. PLEASE STATE ALL MEDICATION YOU ARE CURRENTLY TAKING, THAT YOU HAVE BEEN TAKING FOR LONGER THAN ONE MONTH. PLEASE STATE HOW YOU ARE TAKING YOUR MEDICATION

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15.

GRADSKA LJEKARNA ZAGREB

questionnaire:

FOR THE FOLLOWING STATEMENTS, INDICATE THE EXTENT TO WHICH YOU AGREE WITH THEM:

	strongly agree	agree	unsure	disagree	strongly disagree
Sometimes I think I take too many medicines					
Taking my medicines every day is very inconvenient					
I spend a lot of money on my medicines					
I feel that my medicines are a burden to me					
I feel that I am taking a large number of medicines					
I feel that I may be taking one or more medicines that I no longer need					
I would like to try stopping one of my medicines to see how i feel without it					
I would like my doctor to reduce the dose of one or more of my medicines					
I think one or more of m medicines may not be working					
I believe one or more of my medicines may be currently giving me side effects					
I would be reluctant to stop a medicine that I had been taking for a long time					
If one of my medicines was stopped, I woukd be worried about missing out on future benefits					
I get stressed whenever changes are made to my medicines					
If my doctor recommended stopping a medicine, I would feel that he/she was giving up on me					
I have had a bad experience when stopping a medicine before					
I have a good understanding of the resons I was prescribed each of my medicines					
I know exactly what medicines I am currently taking, and/or I keep an up-to-date list of my medicines					
I like to know as much as possible about my medicines					
I like to be involved in making decisions about my medicines with my doctors					
I always ask my doctor, pharmacist or other healthcare professional if there is something I don't understand about my medicines					
If my doctor said it was possible I would be willing to stop one or more of my regular medicines					
Overall, I am satisfied with my current medicines					

This is a translated and adapted version of the revised Patients' Attitudes Towards Deprescribing (rPATD) questionnaire with permission from the authors: Reeve, Emily, et al. "Development and validation of the revised patients' attitudes towards deprescribing (rPATD) questionnaire: versions for older adults and caregivers." Drugs & aging 33.12 (2016): 913-928.

	very comfortable	comfortable	unsure	uncomfortable	very uncomfortable
How would you feel if a pharmacist was involved in the process of stopping the use of one or more of your regular medications, and provided follow up? (in collaboration with your physician)					
	telephone call	pharmacy visit	mail/e-mail	no follow-up	other
If you were to stop using one or more of your regular medication in collaboration with your pharmacist and physician, what follow-up method would you prefer?					
	yes		unsure		no
Do you believe your pharmacist has enough knowledge, skills, and information about your medications to suggest deprescribing to you and your physician?					
What medication/s would you LIKE to stop taking (that you believe you no longer need, or feel is causing you harm)?					
What medication/s you would NOT LIKE to stop taking?					