ADVERSE DRUG REACTION REPORTING FORM

A. PATIENT'S INFORMATION:

1. Patient's Name:			
2. Gender: ☐ Male ☐ Female		3. Age: _____ Years	4. Weight: _____ Kg
5. Contact Details:	Cell #:	Landline:	Email:

B. SUSPECTED ADVERSE REACTION:

6. Date of reaction started	D	D	/	M	M	/	Y	Y
7. Date of recovery	D	D	/	M	M	/	Y	Y
8. Describe reaction or problem:								
9. Other relevant history of the patient (Allergies, Smoking, Alcohol Use, Hepatic/ Renal Problems, and Pre-Existing Medical Problems etc.:								
10. Relevant test / Laboratory data with dates*: (use additional pages if necessary):*								

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11. Seriousness of the reaction:

☐ Death D D / M M / Y Y ☐ Disability

☐ Life threatening ☐ Congenital anomaly

☐ Hospitalization – Initial or Prolonged ☐ Required intervention to prevent permanent impairment / damage

☐ Other (Specify)

12. Outcome:

☐ Fatal ☐ Recovering ☐ Unknown

☐ Continuing ☐ Recovered ☐ Other (specify)

C. SUSPECTED MEDICATION(S):

Brand Name and/or generic Name	Manufacturer / Importer	Batch No	Route of administration & Daily Dose	Strength & Dosage	Start Date	Stop Date	Prescribed for

D. REPORTER DETAILS:

Name:		Professional Address:	
Specialty:		Telephone No.:	
Email Address:		Date of this report:	

Sign / Stamp _____