ADVERSE REACTION REPORTING FORM

(Please complete all sections as much as possible)

(A) PATIENT DETAILS

Age/Date of Birth (dd/mm/yyyy): / / Wt (kg): ……
Gender: M ( ) F ( ) If female, Pregnant Yes ( ) No ( ) Age of pregnancy……..
Name/Folder Number …… Telephone No:…….
Hospital/Treatment Centre……

(B) DETAILS OF ADVERSE REACTION AND ANY TREATMENT GIVEN (Attach a separate sheet and all relevant laboratory tests/data when necessary)

Date reaction started (dd/mm/yyyy): / / Date reaction stopped (dd/mm/yyyy): / /

(C) OUTCOME OF ADVERSE REACTION:

Recovered ( ) Not yet recovered ( ) Unknown ( )
Did the adverse reaction result in any untoward medical condition? Yes ( ) No ( ) If yes, Specify……
SERIOUSNESS: Death ( ) Life threatening ( ) Disability ( ) (specify)…… Hospitalization ( )
Others (specify)…….

(D) SUSPECTED PRODUCT(S) (Attach sample or product label if available)

Brand name	**Generic name**	**Batch Number**	**Expiry date**	**Manufacturer**
Reasons for use (Indication):		**Dosage Regimen:**	**No. of days given:**	**Route of Administration:**
Date started: (dd/mm/yyyy) / / Date stopped: (dd/mm/yyyy) / / *Did the adverse reaction subside when the drug was stopped (de-challenge)*? Yes ( ) No ( )				
Was the product prescribed? Yes ☐ No ☐		**Source of Drug:**		

Was product re-used after detection of adverse reaction (re-challenge)? Yes ( ) No ( )
Did adverse reaction re-appear upon re-use? Yes ( ) No ( )

(E) CONCOMITANT DRUGS: INCLUDING COMPLEMENTARY MEDICINES, CONSUMED AT THE SAME TIME AND/OR 3 MONTHS BEFORE

(Attach a separate sheet when necessary)

Name of Drug	**Daily dose**	**Date started**	**Date stopped/ Ongoing**	**Reason(s) for use**

(F) REPORTER DETAILS

Name of Reporter: ……Profession……..
Institution's Address:……..……
Signature: ……Tel……E-mail……..…….
Date (dd/mm/yyyy) : / /

****Confidentiality**: Identities of the reporter and the patient will remain strictly confidential***