Adverse Drug Reaction Reporting Form

1. PATIENT INITIALS (first, last)	1a. COUNTRY	2. DATE OF BIRTH			2a. AGE Years	3. SEX	4-6 REACTION ONSET			8-12 CHECK ALL APPROPRIATE TO ADVERSE REACTION
		Day	Month	Year			Day	Month	Year	
7 + 13 DESCRIBE REACTION(S) (including relevant tests/lab data)										☐ PATIENT DIED ☐ INVOLVED OR PROLONGED INPATIENT HOSPITALISATION ☐ INVOLVED PERSISTENCE OR SIGNIFICANT DISABILITY OR INCAPACITY ☐ LIFE THREATENING ☐ CONGENITAL-ANOMALY ☐ OTHER (SPECIFY)
14. SUSPECT DRUG(S) (include generic name)										20. DID REACTION ABATE AFTER STOPPING DRUG? ☐ YES ☐ NO ☐ NA
15. DAILY DOSE(S)		16. ROUTE(S) OF ADMINISTRATION								21. DID REACTION REAPPEAR AFTER REINTRO-DUCTION?
17. INDICATION(S) FOR USE										☐ YES ☐ NO ☐ NA
18. THERAPY DATES (from/to)		19. THERAPY DURATION								
22. CONCOMITANT DRUG(S) AND DATES OF ADMINISTRATION (exclude those used to treat reaction)										

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<tr><td colspan="3"></td></tr>
<tr><td colspan="3">23. OTHER RELEVANT HISTORY (e.g. diagnostics, allergies, pregnancy with last month of period, etc.)</td></tr>
<tr><td colspan="2">24a. NAME AND ADDRESS OF MANUFACTURER</td><td rowspan="3">26. REPORTER DETAILS</td></tr>
<tr><td></td><td>24b. MFR CONTROL NO.</td></tr>
<tr><td>24c. DATE RECEIVED
BY MANUFACTURER</td><td>24d. REPORT SOURCE
□ STUDY □ LITERATURE
□ HEALTH PROFESSIONAL</td></tr>
<tr><td>DATE OF THIS REPORT</td><td>25a. REPORT TYPE
□ INITIAL □ FOLLOWUP</td><td></td></tr>
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