



**IN STRICT CONFIDENCE**

TEL: 08158290011

1 \* PATIENTS DETAILS

Full Name or Initials: \_\_\_\_\_ Patient Record No: \_\_\_\_\_  
Age/Date of Birth: \_\_\_\_\_ SEX: M  F  WEIGHT (kg): \_\_\_\_\_  
Hospital/Technical Centre: \_\_\_\_\_

2 \* ADVERSE DRUG REACTION (ADR)

A	<b>DESCRIPTION</b>		<b>C. OUTCOME OF REACTION</b> TICK AS APPROPRIATE	
			<input type="checkbox"/> Recovered fully	<input type="checkbox"/> Recovered with disability (Specify) _____
	DATE Reaction Started	DATE Reaction Stopped	<input type="checkbox"/> Congenital abnormality (specify) _____	<input type="checkbox"/> Life Threatening (Specify) _____
			<input type="checkbox"/> Death	<input type="checkbox"/> Others (specify) _____

B Was Patient Admitted Due to ADR Yes  No   
If already Hospitalized, was it prolonged Due to ADR  
Duration of Admission (days) \_\_\_\_\_  
Treatment of Reaction: \_\_\_\_\_

3	* Indication For Use	Dosage	Route Of Administration	Dated Started	Date Stopped

4 CONCOMITANT MEDICINES (All medicines taken within the last 3 months including herbal and self medication)

Brand or Generic Name	Dosage	Route	Date started	Dated stopped	Reasons for use

5 \* SOURCE OF REPORTS:

Name Of Report: \_\_\_\_\_  
Address: \_\_\_\_\_  
Profession: \_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Tel No./E-mail: \_\_\_\_\_

**\* MANDATORY FIELDS**