SOP/PV-700/F03- 00

Date:
Case Serial No:

Adverse Drug Reaction (ADR) Reporting Form

A. Patient Details

Patient name (Optional):	Age:	Gender: ☐ Male ☐ Female	Weight:	Height:

B. Reporter Details

Reporter name:	Relationship to the patient:
Address:	E-mail:
Phone / Mobile:	

C. Suspected Product Information

Type of product:	☐ Medicinal product ☐ Herbal product ☐ Vaccine ☐ Food Supplement ☐ Other
Trade Name Batch Number:	Active ingredient name: Manufactured Name:
How did you obtain the product:	☐ From the pharmacy with prescription ☐ From the pharmacy without prescription ☐ From other places (non-pharmacy), specify:
Name and address of the establishment from which the product was dispensed:	
Dosage form of the product:	☐ Tablets ☐ Capsules ☐ Syrup ☐ Suppositories ☐ Eye/Ear drops ☐ Injection ☐ Topical ointment/cream ☐ Herbs/Herbal mixture ☐ Eye/Ear ointment ☐ Spray ☐ Patches ☐ Other, specify:
Date of starting use of the product:	Route of administration:
Purpose of use:	Dosage:
Did you stop using the product: ☐ Yes ☐ No	

D. Adverse Drug Reaction (ADR) Description

Date of event started:	Date of event disappeared, if applicable:

E. Seriousness of ADR ☐ Serious (If the case is serious, specify one of the conditions listed below) ☐ Non-serious ☐ Un-known

☐ Patient died, date:	☐ Life threatening	☐ Permanent disability
☐ Hospitalization	☐ Prolonged hospitalization more than 24 hr	☐ Congenital anomaly
☐ Required intervention to prevent permanent impairment/ damage		☐ Required Emergency Room (ER) visit
☐ Other……		

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F. Action Taken

☐ Drug withdrawal	☐ Dose reduced	☐ Dose increased	☐ Dose not changed	☐ Unknown	☐ Not applicable

G. Outcome of ADR (Tick all applicable)

The patient	☐ Recovered, date:	☐ Recovering	☐ No improvement	☐ Unknown

G. Additional Information

Was the doctor or pharmacist informed about these symptoms?	☐ Yes	☐ No	☐ Un-known
If yes, did they complete the adverse reaction reporting form?	☐ Yes	☐ No	☐ Un-know
May we obtain additional information from your treating physician?	☐ Yes	☐ No	☐ Un-know

Doctor's Name:	Hospital:	Phone Number:

- **Privacy:**

The information provided in the report is treated with strict confidentiality and is fully protected, including the identity of the patient and the person submitting the report. This information cannot be used against the reporter under any circumstances.