In strict confidence

ADVERSE DRUG REACTION/INDIVIDUAL CASE SAFETY REPORTING FORM

(A) PATIENT DETAILS

Age/Date of Birth (dd/mm/yyyy): / / Gender: M ( ) F ( ) Wt:……kg

Name/Folder Number…… Tel No.:……

Hospital/Treatment Centre……

(B)DETAILS OF ADVERSE REACTION AND ANY TREATMENT GIVEN (Attach a separate sheet if need be)

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

(C)OUTCOME OF ADVERSE REACTION

Recovered ( ) Not yet recovered ( ) Unknown ( )

WHEN COMPLETED, PLEASE CALL **0243559308** FOR PICK UP

Please note that this report does not constitute an admission that the reporting medical professional or the suspected product caused or contributed to the event.

Did the adverse reaction result in any untoward medical condition? Yes ( ) No ( ) Specify if yes…….

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 no.**	**Expiry date**	**Manufacture**
Reason(s) for use (indication)		**Daily dose**	**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 product:**	

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

Did adverse reaction re-appear upon re-use? Yes ( ) No ( )

(E)CONCOMITTANT DRUGS INCLUDING HERBAL MEDICINES TAKEN PRIOR TO THE ADVERSE REACTION (Attach a separate sheet if need be)

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

Attach all relevant laboratory test/data

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(F) REPORTER DETAILS

Name of Reporter:…….Profession……..

Address…….

Signature:……Tel no……E-mail……..

Date (dd/mm/yyyy)

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