Pharmacovigilance Department

Form: Collection of ADR information

ADVERSE EVENT REPORT	**Page 1 of 2**

PATIENT INFORMATION:

Patient initials: COUNTRY:	**Date:**

REPORT TYPE: ☐ Initial ☐ Follow-up							
DATE OF BIRTH	AGE	RACE	SEX	HEIGHT	WEIGHT	ONSET DATE	RECOVERY DATE
DD/MM/YYYY			☐ Male			DD/MM/YYYY	DD/MM/YYYY
			☐ Female				

ADVERSE EVENT INFORMATION:

ADVERSE EVENT(S) IN MEDICAL TERMS (diagnosis, if possible)	Seriousness criteria Check all appropriate to event
Description of event:	☐ Patient died
	☐ Involved or prolonged inpatient hospitalization ☐ Involved persistent or significant disability or incapacity ☐ Life-threatening ☐ Congenital anomaly/birth defect ☐ Other significant medical events

HISTORY:	TEST / LABORATORY FINDINGS (enter only those findings necessary for AE diagnosis or course description)
PATIENT'S RELEVANT MEDICAL HISTORY (e.g. co-existing medical conditions such as disease, allergies, similar experiences)	

SUSPECT DRUG INFORMATION:

Product Name		Manufacturer	Batch/lot number	Expiry date	Dose	Route of use	Frequency	Therapy dates (from) (To)		Indication
Brand name	Generic Name							DD/MM/YYYY	DD/MM/YYYY	

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CONCOMITANT DRUGS

DRUG NAME(S)		DOSE	THERAPY DATES (from) DD/MM/YYYY	(To) DD/MM/YYYY	REASON FOR USE
Brand name	Generic Name				

ACTION TAKEN WITH SUSPECT DRUG (mark all as appropriate)

☐ No Action Taken ☐ Withdrawn ☐ Treatment taken

Did Reaction Disappear After Stopping Drug?
☐ Yes ☐ No ☐ Not Applicable ☐ Unknown

Did Reaction Reappeared After Restarting of Drug?
☐ Yes ☐ No ☐ Not Applicable ☐ Unknown

OUTCOME OF THE PATIENT/AE

☐ Completely Recovered	Date of recovery:	DD/MM/YYYY	☐ Condition still present and unchanged
☐ Recovered with sequelae			☐ Condition deteriorated
☐ Condition improving			☐ Death Autopsy: ☐ No ☐ Yes

ASSESSMENT OF CAUSALITY

☐ Probable ☐ Possible ☐ Not Related ☐ Unknown

REPORTER'S INFORMATION:

NAME, ADDRESS, TELEPHONE NUMBER AND EMAIL OF REPORTER

DATE OF THIS REPORT
DD/MM/YYYY

☐ HCP ☐ CONSUMER ☐ OTHER

Signature:

Senders Contact details:

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