	SUSPECTED ADVERSE REACTION REPORTING FORM	MCA-F-305/01

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1	**PATIENT'S DETAILS**					
	Patient initials / number (*first, middle, last*)	Date of Birth (*day/month/year*)	Age	Sex **M** ☐ **F** ☐	Weight (kg)	Reaction start date (*day/month/year*)

2	**ADVERSE REACTION**	
	Description of reaction (*including relevant tests/lab data*)	Outcome of reaction (*Tick all as appropriate*)
		Patient died ☐ Life-threatening ☐ Involved or prolonged Hospitalisation ☐ Persistent/ significant disability/incapacity ☐ Congenital anomaly/ birth defect ☐
	Treatment of reaction	Recovered ☐

3	**SUSPECTED MEDICINE(S)** (*including Biologicals, Herbal medicines*) (*state brand and generic name, batch/lot number, expiry date, name and address of manufacturer and attach product label/ sample if available*)	Did reaction abate after stopping medicine?
		Yes ☐ No ☐ Unknown ☐
	Indication for use	Did reaction reappear after reintroduction?
		Yes ☐ No ☐ Unknown ☐

	Dosage	Route	Date Started (*day/month/year*)	Date Stopped (*day/month/year*)

4	**CONCOMITANT MEDICIATION** (All medicines taken within the last 3 months including herbal medicines and self-medication, but excluded those used to treat reaction)				
	Brand or Generic Name	Dosage	Route	Date started (*day/month/year*)	Date stopped (*day/month/year*)

4	**SOURCE OF REPORT**			
	Name and address of reporter			Date of this report (*day/month/year*)
	Profession	Tel No/E-mail	Report Type	
			Initial ☐	Follow-up ☐