|  |  |
| --- | --- |
| **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 [ ]  |
| Did reaction reappear after reintroduction? |
|  | Indication for use |
|  |  | 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 [ ]  |