|  |  |
| --- | --- |
| **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, etc.*) | 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)** (*state brand &generic name, batch number, expiry date, name & address of manufacturer, indicate medication error, product defect, etc.*) | Did reaction abate after stopping medicine? |
|  |  | [ ]  Yes [ ]  No[ ]  Unknown  |
| Did reaction reappear after reintroduction? |
|  | Indication for use |
|  |  | [ ]  Yes [ ]  No[ ]  Unknown [ ]  NA |
|  | 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 |