|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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 | | | | |