	SUSPECTED ADVERSE REACTION REPORTING FORM	MCA-F-305/01
Date received by MCA: _____	MCA AR #:	

Off Bertil Harding Highway, Kotu East, P.O. BOX 3162, Serekunda, email / website: info@mca.gm / www.mca.gm

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 ☐ Recovered
	Treatment of reaction	

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
	Indication for use	Did reaction reappear after reintroduction?
		☐ 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