SUSPECTED ADVERSE DRUG REACTION REPORTING FORM

For VOLUNTARY reporting of Adverse Drug Reactions by healthcare professionals

	AMC/ NCC Use only
	AMC Report No.
	Worldwide Unique No.

A Patient Information

1.Patient Initials	2. Age at time of Event or date of birth	3. Sex ☐ M ☐ F 4. Weight ____ Kgs

B Suspected Adverse Reaction

5. Date of reaction stated (dd/mm/yyyy)

6. Date of recovery (dd/mm/yyyy)

7. Describe reaction or problem

12. Relevant tests / laboratory data with dates

13 Other relevant history including pre-existing medical conditions (e.g. allergies, race, pregnancy, smoking, alcohol use, hepatic/ renal dysfunction etc)

14 Outcomes

☐ Fatal ☐ Recovering ☐ Unknown

☐ Continuing ☐ Recovered ☐ Other (specify)____

C. Suspected medicaton(s)

S.No	8. Name (brand and /or generic name)	Manufacturer (if known)	Batch No./ Lot No. (if known)	Exp. Date (if known)	Dose used	Route used	Frequency	Therapy dates (if known give duration)		Reason for use of prescribed for
								Date started	Date stopped	
i										
ii										
iii										
iv										

SI.No As per C	9. Reaction abated after drug stopped or dose reduced					10. Reaction reappeared after reintroduction				
	Yes	No	Unknown	NA	Reduced dose	Yes	No	Unknown	NA	If reintroduced dose
i										
ii										
iii										
iv										

11 Concomitant medical product including self medication and herbal remedies with therapy dates (exclude those used to treat reaction)

D. Reporter (see confidentiality section in first page)

15. Name and Professional Address : _____

Pin code _____ E-mail _____

Tel. No. (with STD code) _____

Occupation _____ Signature _____

16. Causality Assessment	17. Date of this report (dd/mm/yyyy)

18. Professional identification number _____

19. Approving authority _____