Adverse drug reaction (ADR) Reporting Form

1. Patients Information	
Name:	Age:
Country/city:	Date of birth:
Sex:	Contact No/Email:

2. Suspected Drug information
On set reaction date:
Select appropriate adverse reaction:
Describe reaction(s) with relevant test lab:

3. Suspected drug(s) Information	
Generic Name:	Daily Dose:
Batch No:	Exp Date:
Route of Administration:	Indication for use:
Therapy Dates (from/to):	Therapy Duration
Did reaction occur after stopping drug	
Did reaction reappear after reintroduction	

4. Other administered drug(s) and their history
Other administered drug(s) and dates of administration
Other relevant history (allergy, pregnancy with the last month period & diagnosis etc)

5. Reporter(s) Source	
Physician	Pharmacist
Nurse	Relative
Patient	Marketing person

Submit