REPORT OF ADVERSE REACTIONS TO MEDICINES, VACCINES, DEVICES TRADITIONAL REMEDIES & COSMETICS

(Identities of Reporter, Patient and Institution will remain confidential)

PATIENT DETAILS:

BHT/Record No.	Name & Address (Optional)	Age	Ethnicity	Sex	M
					F

ALL MEDICINES IN USE

Suspected Drug-generic & trade name (Batch No. if available)	Dose & frequency	Route	Date Begun	Date Stopped	Reason for use
Other drugs in use:					

DESCRIPTION OF ADVERSE REACTION

Date of onset:

System involved

RESPI	CVS	GIT	CNS	GUT	SKIN	OTHER

Description of the event:

Lab investigations if any:

Outcome: tick "✓" or circle "o"

Recovered	Continuing	Hospitalized	Severity				Date of death:	Birth detect Specify:
			Mild	Moderate	Severe	Fatal		

Result on discontinuation of suspect drug: ✓				**Result on reintroduction of drug: ✓**	**Alternative diagnosis**
Improved	Disappeared	Persisted	Not known	Reappeared : Yes / No / not known	

Risk factors present: ✓

Renal Dysfunction	Cardiac Dysfunction	Hepatic Dysfunction	Previous Allergies	Smoking	Alcoholic	Drug Addict	Other (name)

REPORT ON MEDICINAL DEVICE/COSMETICS/QUALITY PROBLEM

Name (Brand & Generic):	device	cosmetic	Drug:	Date of expiry:
Manufacturer (Name & Address):				Model / serial / Batch /other number:
Description of the problem:				

REPORTING DOCTOR/PHARMCIST/NURSE/DENTIST/OTHER

Name & Designation: ……

Address: ……

Telephone Number: …… Hospital & Ward No: ……

Signature: …… Date of Reporting: ..... / ……../…….. ……

For information contact: Regional ADR Monitoring Unit-Ruhuna, Department of Pharmacology. T.P. 091-2246877, 0912234801, 2234803, Ext 348: Fax: 091-2222314, Attn: Dept. of Pharmacology, Email: pharmacologyruh@gmail.com . Photocopies of the above from are accepted or forms could be obtained from the department.