ADVERSE DRUG REACTION REPORTING FORM

A. PATIENT DETAILS

Patient name

Age at time of onset(yrs)*

Weight (kg)

Patient Number

Health Facility

District

Sex: M/F*

Last Menstrual Period

Trimester (if pregnant)

B. SUSPECTED DRUG (S) DETAILS

Generic Name*

Brand Name

Dose ,Route Frequency

Date* started

Date stopped

Prescribed for Expiry date

Batch No

C. SUSPECTED REACTIONS

Please describe the reaction as observed and any treatment given to manage the reaction;

Outcome:
Recovered
Recovering
Continuing
Death due to reaction

Date reaction started*	Date reaction stopped	Date of notification

SERIOUSNESS OF THE REACTION

Patient died

Prolonged inpatient Hospitalization

Involved disability

Life Threatening

Congenital abnormality

D. CONCOMITANT DRUGS

Please **give** information on the drug(s) the patient has been taking together with the suspected drug including those taken for chronic diseases (include self medication and herbal preparations);

Generic Name

Brand name

Dosage

Date started

Date stopped

Indication(prescribed or OTC)

Relevant laboratory tests including dates

Additional relevant information (medical history, allergies,failure of efficacy)

E. REPORTER'S DETAILS

Name/designation*	Telephone and Email Address	Date of reporting	Health facility