FORM FOR REPORTING OF
SUSPECTED ADVERSE DRUG
REACTIONS

IN STRICT CONFIDENCE

1. * PATIENT’S DETAILS

Full Name or Initials: ____________________________ Patient Record No: ____________________________

AGE/DATE OF BIRTH: ____________________________ SEX: M [ ] F [ ] WEIGHT (kg): ____________________________

HOSPITAL/Treatment Centre: ____________________________

2. * ADVERSE DRUG REACTION (ADR)

A. DESCRIPTION

C. OUTCOME OF REACTION

Tick as appropriate

- Recovered fully
- Recovered with disability (Specify)
- Congenital Abnormality (Specify)
- Life Threatening (Specify)
- Death
- Others (specify)

DATE Reaction Started ____________________________ DATE Reaction Stopped ____________________________

B. Was Patient Admitted Due to ADR

Yes [ ] No [ ]

If Already Hospitalized, Was it Prolonged Due to ADR

Yes [ ] No [ ]

Duration of Admission (days): ____________________________

Treatment of Reaction: ____________________________

3. * SUSPECTED DRUG (Including Biologicals Traditional/Herbal Medicines & Cosmetics)

A. DRUG DETAILS

(State name and other details if available / Attach product label / Sample (if available)

Brand Name: ____________________________ Generic Name: ____________________________ Batch No: ____________________________

NAFDAC No: ____________________________ Expiry Date: ____________________________

Name & Address of Manufacturer: ____________________________

B. Indications for Use Dosage Route of Administration Date Started Date Stopped

4. * CONCOMITANT MEDICINES

(All medicines taken within the last 3 months including herbal and self medication)

<table>
<thead>
<tr>
<th>Brand or Generic Name</th>
<th>Dosage</th>
<th>Route</th>
<th>Date Started</th>
<th>Date Stopped</th>
<th>Reason for Use</th>
</tr>
</thead>
</table>

5. * SOURCE OF REPORT:

Name of Reporter: ____________________________ Address: ____________________________

Profession: ____________________________ Signature: ____________________________

Tel No/E-mail: ____________________________

*: MANDATORY FIELDS