Dallah Pharma Company شركة دله فارما

Adverse Drug Reaction Reporting Form

1. Patient Details:

Patient Name/ Initial: …….. Sex: □ Male □ Female , Pregnant □ Yes □ No

Age: …… Hight: ……. Weight: ……

2. Describe the Side effect(s)

……
……
……
……
……
……
……

How bad was this side effect? (You can chose more than one)

□ Mild
□ Effect daily activities
□ Admitted to hospital or prolong hospitalization
□ Other medically important condition (Please Specify)……
□ Caused serious illness
□ Caused Death
□ Cause Congenital /Birth defect

3. Suspected Medication Information:

Medication/s Name:
1.
2.

Reason for use:
Dose and Strength:
Start Date: / /

Did the patient stop because of side effect? □ No □Yes , Date / /

Comments (eg: relevant history, allergies, previous exposure to the drugs ……..etc.
……
……
……
……
……

Did reaction(s) disappear after discontinuation of suspected drugs(s)?
□ Yes □ No □ Unknown

4. Concomitant Medications (any other Medication that the patient is taking) and Medical History (any chronic diseases that the patient has)

Concomitant Medications:	Medical History:
1.	**1. .....**
2.	**2. .....**
3.	**3. .....**
4.	**4. .....**

5. Reporter's Information:

Name: **,Status : □ Physician □ Dentist □ Pharmacist Other,.....**
Address: **Mobile Number:**
E-mail: **Date: / /**
Signature:

Please send this report to:
Hananalrashid_pv@dallah-pharma.com