

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)

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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 drugsetc.

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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:

1.
2.
3.
4.

Medical History:

1.
2.
3.
4.

5. Reporter's Information:

Name:

Address:

E-mail:

Signature:

,Status : Physician Dentist Pharmacist Other,.....

Mobile Number:

Date: / /

Please send this report to:

Pv@dallah-pharma.com