Adverse Drug Reactions Reporting Form

REPORT OF SUSPECTED ADVERSE DRUG REACTION

(Note : identities of Reporter, Patient and Institution will remain confidential)

ADR REPORT NO.	(For office use only)

PATIENT	DIAGNOSIS/ MAIN DISEASE
Name: Address: Sex: Male ☐ Female ☐ Weight: Tribe/ Race:	

ADVERSE REACTIONS

Brief Description of adverse Reaction(s)	Time/ Onset of adverse Reaction(s)	Outcome (Please Mark X in the Box)
		☐ Recovered without sequel ☐ Recovered with sequel ☐ Not yet recovered ☐ Unknown ☐ Fetal, Date of death.....

Treatment (of Reactions)

Drug Reaction Relationship : (Please Mark X in Box)

Certain ☐ Probable ☐ Possible ☐ Unlikely ☐ Unclassifiable ☐

DRUGS

Drug(s) Trade/ Generic Name and Strength	Dosage Form	Mark for Suspected Drugs	Dosage Regimen		Route	Administtration		Indication
			Dosage	Frequency		Date Began	Date Terminated	

Comment s : (e.g. Relevant history, allergies, exposure to the drugs etc.)

Reporting Doctor/ Pharmacist ☐ ☐

Name & Designation : ..... Signature : ....

Address : ..... Date : ....