Pharmacovigilance
التيقظ الدوائي

Version: 1

ADVERSE DRUG REACTION REPORTING FORM

1. PARTICULARS OF PATIENT

Patient Initials: …….. Country: ……..
Date of Birth: …… Age: …….. Weight (kg): ……
Patient address: …….

Sex: ☐ Male Nationality: ……
☐ Female
Pregnant: ☐ Yes ☐ No ☐ Not applicable

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2. ADVERSE EVENT

Describe the Reaction(s):

Tick appropriate box with reference to the adverse drug reaction:

☐ Requires or prolongs hospitalization ☐ Life threatening ☐ Death

☐ Permanently disabling or incapacitating ☐ Congenital anomaly

☐ Other medically important condition (Please Specify): …….

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3. SUSPECTED DRUG

Brand Name of Suspected Drug: …….. Generic Name: …….
Batch Number: ……..... Duration of treatment: ……....
Daily dose: ……. Indication for use(s): ……
Route of administration: ……..

Discontinuation of Drug because of event: ☐ No ☐ Yes Dated: ……

4. CONCOMITANT DRUGS AND MEDICAL HISTORY:

Concomitant Drugs (any other drugs that the patient is taking) and Medical History (any diseases that the patient has for example: Diabetes, Hypertension, etc.):

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5. REPORTER'S INFORMATION

Name: ……. Address: ……

Country: ……. Phone Number: …….

Report Source:

- ☐ Patient
- ☐ Doctor
- ☐ Pharmacist
- ☐ Others: ……