SUSPECTED ADVERSE DRUG REACTION

If you are suspicious that an adverse reaction maybe related to a drug or combination of drugs please complete this form. Please report all adverse reactions for black triangle drugs and only serious adverse reactions for established drugs. Do not put off reporting because some details are not known.

Patient Initial ________________________________ **Sex**: M / F **Weight if known (kg**) ______

Age (at time of reaction): ____________ **Identification** (Your Practice / Hospital Ref.): ______________

SUSPECTED DRUG(S)

Give brand name of drug and Batch number if known	Route	Dosage	Date Started	Date stopped	Prescribed for
_________________________	_______	_____	_________	___________	______________
_________________________	_______	_____	_________	___________	______________
_________________________	_______	_____	_________	___________	______________

SUSPECTED REACTION (S)

Please describe the reaction(s) and any treatment given:

Outcome

- Recovered ☐
- Recovering ☐
- Continuing ☐
- Other ☐

Date reaction (s) started: ____________ Date reaction (s) stopped: __________

Do you consider the reaction to be serious? Yes / No

If yes, please indicate why the reaction is considered to be serious (please tick all that apply:

- Patient died due to reaction ☐
- Life threatening ☐
- Congenital abnormality ☐
- Involved or prolonged inpatient hospitalization ☐
- Involved persistent or significant disability or incapacity ☐
- Medically significant; please give details:

OTHER DRUGS (including self-medication & herbal remedies)

Did the patient take any other drugs in the last 3 months prior to the reaction? Yes / No

If yes, please give the following information if known:

Drugs (Brand, if known)	**Route**	**Dosage**	**Date started**	**Date stopped**	**Prescribed for**
_________________________	_______	_____	_________	_______	___________
_________________________	_______	_____	_________	_______	___________
_________________________	_______	_____	_________	_______	___________

Additional relevant information e.g. medical history, test results, known allergies, rechallenge (if performed), suspected drug interactions. For congenital abnormalities please state all other drugs taken during pregnancy and the last menstrual period.

REPORTER'S DETAILS

Name & Professional Address: ____________________

____

____

Post Code: _______________ **Tel No.** ___________

Specialty: ________________________________

Signature: ________________ **Date:** ______

CLINICIAN (If not the reporter)

Name & Professional Address**:** ______________

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Tel. No. ______________ **Post code:** ________

Specialty: ________________________________

Signature: _______________ **Date:** _________

Form should be photocopied in triplicate and sent as indicated below:

Original (Pharmacy), 1 Copy (Patient's Docket), 1 Copy (Patient)