Adverse Drug Reactions (ADR)/ Drug Related Problems Reporting Form

1. Patient Information

Patient Name/ Initials: **Gender:** □ **Male** □ **Female** **Pregnant?** □ **Yes, which trimester?** □ **No**

Age: **Phone Number:** **Weight:** **Height:**

2. Suspected Drug

	Drug Name	Drug Strength	Daily Dose	Route of administration (oral, injection, etc.) / Dosage form (tablets, capsules, syrup, etc.)	Start Date	Stop Date	Indication	Batch Number
Suspected Drugs								
Other Drugs								

3. Adverse Drug Reaction

Adverse drug reaction description	History of preexisting medical conditions, or previous use of the drug, additional data…	Adverse drug reaction seriousness: □ Fatal □ Life threatening □ Cause permanent disability □ Leads to hospitalization □ Prolong the hospital stay □ Leads to congenital anomalies □ Requires medical/ surgical intervention to prevent permanent disability or problem. □ Other, …..
Starting date of the adverse drug reaction:		**Date when the adverse drug reaction stopped:**
Did the adverse drug reaction stop? □ **Yes** □ **No** **Did the adverse drug reaction recur after re-using the drug?** □ **Yes** □ **No** **Did the adverse drug reaction stop after discontinuing the drug?** □ **Yes** □ **No**		**Current patient status:** □ Fully recovered □ Full recovery is expected □ Hospitalized □ Died □ Unknown □ Other, ……

4. Other Drug Related Problems

Description of the drug related problem	**Drug related problem:** □ Lack of efficacy □ Manufacturing defects □ Medication errors □ Drug misuse □ Other, …..
	Date of the problem:

5. Reporter Information

Reporter Name: **Phone Number:** **Address:** **E-mail:**