Medical Union Pharmaceuticals

Medical Affairs Department
Pharmacovigilance Division

Adverse Reaction Reporting Form

A. Reporter details

Name: Specialty: Address:

Tel.: Fax/E-mail: Date of report:

B. Patient details

Name: Age / Date of birth: Weight (kg):

Sex: Patient contact details:

C. Suspected drug(s)

Drug name (Generic & trade)	Conc.	Route	Dose & Frequency	Used for	Date Started	Date Stopped	Batch No.

D. Suspected reaction(s)

Please describe the reaction(s):

Date reaction started: -- / -- / ---- Date reaction stopped: -- /-- / ----

Action taken towards AR: ( ) Drug withdrawn ( ) Dose reduced ( ) Dose increased
( ) Dose not changed ( ) Unknown

Treatment given for AR (if any):

Outcome of the reaction: ( ) Recovered ( ) Recovering ( ) No improvement ( ) Unknown

Does the reaction Stopped after stopping the drug? ( ) Yes ( ) No ( ) I don't know

Does the reaction Reappeared after retaking the drug? ( ) Yes ( ) No ( ) I don't know

E. Seriousness of adverse reaction

( ) Patient Died ( ) Life threatening ( ) Hospitalization ( ) Prolonged hospitalization

( ) Congenital Anomaly ( ) Permanent Disability ( ) Required intervention to prevent damage

( ) Other, Specify:

Relevant tests / laboratory data including dates:

Other relevant History, including pre-existing medical conditions (e.g. allergies, pregnancy, smoking, renal dysfunction etc)

F. List of other drugs taken (please list any other drugs taken during the last month prior to the reaction)

Drug name (Generic & trade)	Conc.	Route	Dose & Frequency	Used for	Date Started	Date Stopped	Batch No.

G. MUP member details

Name: Tel.: E-mail:

Scientific Office: Region: Line: Date report received:

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