Adverse Drug Reaction Reporting Form

Date Of Event

Event Date* dd/mm/yyyy

Reporter Details

Full Name*

Email ID*

Phone*

Address

Patient Information

Full Name

Email ID*

Gender*

☐ Male ☐ Female

Age/ Date of Birth*

dd/mm/yyyy

Weight

KG

Telephone*

Address

Adverse Drug Reaction

Description of Event*

Start Date of Reaction*

End Date of Reaction

dd/mm/yyy

Is the ADR serious?*

☐ Yes ☐ No

If YES REASON FOR SERIOUSNESS

Suspected Medication

Drug Name*

Generic Name*

Strength

Batch No

Mfg Date

Expiry Date

Daily Dose

Indication

Start Date*

dd/mm/yyy

Stop Date

dd/mm/yyy

Concomitant Medication (S)

Drug Name

Generic Name

Daily Dose

Indication

Start Date

dd/mm/yyy

Stop Date

dd/mm/yyyy

Action taken to Treat ADR

☐ Medical Treatment ☐ Drug Stopped ☐ Drug Reduced

Did the ADR subside after stopping the suspected medication

☐ Yes ☐ No

Medical History

Condition

Onset

Details

Present

☐ Yes ☐ No

Outcome of the Adverse Reaction

☐ Recovered ☐ Recovering ☐ No improvement ☐ Unknown

Pharmacy/Hospital Name

Pharmacy

Hospital

Name of Healthcare Professional*

Signature*

Date*

dd/mm/yyy

Additional Information

*Indicates mandatory fields

Please send reporting form and supportive document to:
PHARMAX PHARMACEUTICALS FZ.LLC, U.A.E
E-mail: medicines.info@pharmax.ae
Tel: +971-4-2486515