Patient's information
Name:
Age:
Gender:
Address (if available):
Contact number (if available):
Hospital/facility seen or admitted:

Details of Adverse reaction
Date of onset:
Duration:
Do you consider the reaction to be serious?

- Yes, if yes indicate why:
  - Patient died due to reaction
  - Involved or prolonged in-patient hospitalization
  - Life threatening
  - Involved persistent or significant disability
  - Congenital anomaly in the newborn
  - Other outcome, please give details:
- No

Can this be due to Medication Error? No Yes

*Suspected drug product(s) Indicate brand name	Daily Dose	Route	Reason(s) for using the product (Indication)	Date started	Date stopped (if applicable)

Reporter's Detail
Name:
Contact number:
Email: