PDS – FDA MedWatch

Adverse Drug Reaction (ADR) Reporting Form

Patient 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: (tick/mark one)
  - o Patient died due to reaction
  - o Involved or prolonged in-patient hospitalization
  - o Life threatening o Involved persistent or significant disability
  - o Congenital anomaly in the newborn
  - o Other outcome, please give details:_____
    _____
- No

Can this be due to Medication Error?(encircle one) o No o Yes

Please email form to secretariat@pds.orpg.ph

*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 Details

Name:

Contact number:

Email:

Please email form to secretariat@pds.orpg.ph