KOFIKROM PHARMACY LIMITED

Adverse Reaction Reporting Form

Age/Date of Birth (dd/mm/yyyy): ……...Gender: M ( ) F ( ) Wt.: ……...kg
Name/Folder Number ……...Telephone No……
Hospital/Treatment Centre/Pharmacy…….

(B) DETAILS OF ADVERSE REACTION AND ANY TREATMENT GIVEN (Attach a separate sheet when necessary)

Date reaction started (dd/mm/yyyy): ……Date reaction stopped (dd/mm/yyyy)…….....

Recovered ( ) Not yet recovered ( ) Unknown ( )

(C) OUTCOME OF ADVERSE REACTION:

Did the adverse reaction result in any untoward medical condition? Yes ( ) No ( ) If yes, Specify
……
SEVERITY: Death ( ) Life threatening ( ) Disability ( ) (specify)……...……..
Hospitalization ( ) ……'Others (specify)…….……

(D) SUSPECT PRODUCT(S) (Attach sample or product label if available)

Brand name	Generic name	Batch no.	Expiry date	Manufacturer

Reasons for use (Indication)	Daily dose: Route of Administration:

Date started: Date stopped:
Did the adverse reaction subside when the drug was stopped (de-challenge)? Yes ( ) No ( )

Was the product prescribed? Yes ( ) No ( )	Source of Drug:

Was product re-used after detection of adverse reaction (re-challenge)? Yes ( ) No ( )
Did adverse **reaction** re-appear upon re-use? Yes ( ) No ( )

(E) CONCOMITANT DRUGS INCLUDING HERBAL MEDICINES TAKEN PRIOR TO THE ADVERSE REACTION (Attach a separate sheet when necessary)

Name of Drug	Daily dose	Date started	Date stopped	Reasons for use

Attach all relevant laboratory tests/data

(F) DETAILS OF REPORTER

Name of Reporter: ……....
Address……..
Profession: ……
Telephone: ……E-mail: ……
Signature…..…… …….Date (dd/mm/yyyy): .....