Date received (awareness date):
By:

Adverse Drug Reactions (ADRs) Reporting Form
For Health Care Professionals

A. Patient Details

Patient name or initial (Optional):	**Date of birth:**	**Height:**	**Weight:**
Health Institution:	**Medical Record No:**	**Age:**	**Sex:** □ M □ F

B. Suspected Drug

JPM Drug Name	Dose and Frequency	Route/Dose Form	Start Date	Stop Date/ Ongoing	Indication	BatchNumber, Expiration Date	If Batch Number is Not Available

OTHER MEDICATIONS (Including over the counter medications)

Indication	Stop Date/Ongoing	Start Date	Dose / Frequency	Drug.

C. Adverse Drug Reaction

Adverse event including relevant tests/lab data and dates	**Other relevant history, including preexisting medical conditions** *(diagnosis, allergies, pregnancy, hepatic, renal etc)*
Date of event started:	Date of event disappeared, if applicable:

D. Action Taken

□ **Drug withdrawn.** □ **Dose reduced.** □ **Dose increased.** □ **Dose not changed.** □ **Unknown.** □ **Not applicable.**

E. Outcome of ADR (Tick all applicable)

The patient	□ **Recovered, date:**	□ **Recovering**	□**No improvement**	□ **Fatal**	□**Unknown**
Event subsided after stopping (dechallenge)			□**No**	□ **Yes**	□ **Unknown**
Event reappear after reintroducing (rechallenge)			□**No**	□ **Yes**	□ **Not applicable**
Specific antagonist or treatment used:			□**No**	□**Yes, specify:**	

F. Seriousness of ADR (Tick all applicable)

□ **Patient died, date:** □ **Life threatening** □ **Permanent disability**
□ **Hospitalization** □ **Prolonged hospitalization more than 24 hr.** □ **Congenital anomaly**
□ **Required intervention to prevent permanent impairment/ damage** □ **Required Emergency Room (ER) visit**
□ **Cancer** □ **Others……..…**

G. Reporter Details

Reporter name :		**Profession (Specialty):**	
Address:		**E-mail:**	
Phone / Mobile:	**Fax :**	**Date:**	**Signature:**