ADVERSE DRUG REACTION REPORTING FORM

1. PARTICULARS OF PATIENT*

Patient Initials: …… Country: …… Date of Birth: …… *Age (At the time of event): ……...
Weight (kg): …… Height (cm): …… Patient address: ……. *Sex: ☐ Male ☐ Female
*Pregnant: ☐ Yes ☐ No ☐ Not applicable Pregnancy week: …….

2. ADVERSE EVENT*

Date of reaction started*: …… Date of recovery (If applicable): ……
Describe the Reaction(s) or problem*:

3. SERIOUSNESS OF THE REACTION

Tick appropriate box with reference to the adverse drug reaction:

☐ Life threatening
☐ Death (date): ……..
☐ Congenital anomaly
☐ Requires or prolongs hospitalization
☐ Permanently disabling or incapacitating
☐ Other medically important condition (Please Specify): ……

4. OUTCOME OF THE REACTION

☐ Fatal
☐ Recovering
☐ Recovered
☐ Continuing
☐ Unknown
☐ Other (Please Specify): ……

5. SUSPECTED MEDICATIONS or DRUGS*

Brand Name*	Generic Name*	Manufacturer	Batch No	Strength	Dose*	Route*	Dosage form*	Purpose of use	Duration of treatment	Drug discontinued or dose reduced (De-challenge)	Reaction stopped after drug discontinuation (Yes/No/NA)	Reaction reappeared after re-administration (Re-challenge)	Reaction reappeared after re-administration (Yes/No/NA)

6. *CONCOMITANT MEDICATIONS (Other than suspect drugs) *

Concomitant medical product including self-medication and herbal remedies with therapy dates (exclude those used to treat the reaction):

7. MEDICAL HISTORY

Other relevant history including pre-existing medical conditions (e.g., allergies, race, pregnancy, smoking, alcohol use, hepatic/ renal dysfunction etc.)

Have you experienced the same side effect before with the same medicine? ☐ Yes ☐ No

8. RELEVANT TESTS / LABORATORY DATA WITH DATES

9. *PRIMARY REPORTER DETAILS (Patient/Physician/Pharmacist/Nurse/Dentist/ Other healthcare professional) *

Name*: …… Qualification*: …… Reporter organization: ……

Address: …… Town: …… State or province: …… *Country: ……

Phone No.*: …… Email: ……

10. SECONDARY REPORTER DETAILS (Med. Rep. / Distributer/ etc.)

Name: …… Qualification: …… Reporter organization: ……

Address: …… Town: …… State or province: …… Country: ……

Phone No.: …… Email: ……

11. CAUSALITY ASSESSMENT – DRUG REACTION CORELATION (By Primary reporter only)

☐ Certain ☐ Possible ☐ Probable ☐ Not related ☐ Unassesable ☐ Unknown

12. DATE OF THIS REPORT (dd/mm/yy):

Confidentiality: The patient's identity is held in strict confidence and protected to the fullest extent. Jamjoom staff is not expected to and will not disclose the reporter's identity in response to a request from the public.

Submission of a report does not constitute an admission that medical personnel or manufacturer or the product caused or contributed to the reaction.

ADVICE ABOUT REPORTING

- **Report adverse experiences with medications**
- **A reaction is serious when the patient outcome is:** 1) Death 2) Life threatening 3) Requires or prolongs hospitalization 4) Permanently disabling or incapacitating 5) Congenital anomaly
- **Report even if:**
- **You're not certain the product caused adverse reaction**
- You don't have all the details, however, point nos. 1, 2, 5, 6, 9, and Points with (*) marks are essentially required.