

<p style="text-align: center; font-weight: bold;">SUSPECT ADVERSE REACTION REPORT</p>	
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I. REACTION INFORMATION

1. PATIENT INITIALS	1a. COUNTRY	2. DATE OF BIRTH			2a. AGE	3. SEX	4-6 REACTION ONSET			8-12 CHECK ALL
(first, last)		Day	Month	Year	Years		Day	Month	Year	APPROPRIATE TO ADVERSE REACTION
7 + 13 DESCRIBE REACTION(S) (including relevant tests/lab data)										<input type="checkbox"/> PATIENT DIED <input type="checkbox"/> INVOLVED OR PROLONGED INPATIENT HOSPITALISATION <input type="checkbox"/> INVOLVED PERSISTENT OR SIGNIFICANT DISABILITY OR INCAPACITY <input type="checkbox"/> LIFE THREATENING

II. SUSPECT DRUG(S) INFORMATION

14. SUSPECT DRUG(S) (include generic name)	20. DID REACTION ABATE AFTER STOPPING DRUG? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA	
15. DAILY DOSE(S)	16. ROUTE(S) OF ADMINISTRATION	21. DID REACTION REAPPEAR AFTER REINTRODUCTION? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA
17. INDICATION(S) FOR USE		
18. THERAPY DATES (from/to)	19. THERAPY DURATION	

III. CONCOMITANT DRUG(S) AND HISTORY

22. CONCOMITANT DRUG(S) AND DATES OF ADMINISTRATION (exclude those used to treat reaction)
23. OTHER RELEVANT HISTORY (e.g. diagnoses, allergies, pregnancy with last menstrual period, etc.)

IV. MANUFACTURER INFORMATION

24a. NAME AND ADDRESS OF MANUFACTURER		
24b. MFR CONTROL NO.		
24c. DATE RECEIVED BY MANUFACTURER	24d. REPORT SOURCE <input type="checkbox"/> STUDY <input type="checkbox"/> LITERATURE <input type="checkbox"/> HEALTH PROFESSIONAL <input type="checkbox"/> REGULATORY AUTHORITY <input type="checkbox"/> OTHER	
DATE OF THIS REPORT	25a. REPORT TYPE <input type="checkbox"/> INITIAL <input type="checkbox"/> FOLLOW-UP	