مصنع المحاليل الطبية
Pharmaceutical Solutions Industry

Individual Case Safety Report (ICSR) Reporting Form for Health Care Professionals

Date received: By:

A) Patient Details			
Patient Name or Initial		Health Instantiation	
Date of Birth		Gender	
Weight		Height	
Medical Record No.		Age	

B) Suspected Drug (s)					
Drug Name	Batch No.	Dose/ Route/ Frequency	Start Date	End Date	Purpose to Use

D) Adverse Drug Reaction	
Adverse event including relevant tests/lab data and dates	Other relevant history, including pre-existing 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□ Drug withdrawn.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. □ Prolonged hospitalization more than 24 hr. □ Congenital anomaly □ Hospitalization □ Required intervention to prevent permanent impairment/ damage □ Cancer □ Required Emergency Room (ER) visit □ Others …….

G) Reporter Details	
Reporter Name :	Profession (Specialty):
Address:	Phone / Mobile:
E-mail:	Fax:
Signature:	Date: