مصنع المحاليل الطبية
Pharmaceutical Solutions Industry

Reporting Adverse Reaction and Quality Issue Form

Date: **(Filled by community)**

1- End-user Data			
Name (optional)		Date of birth	
Sex		Age	
Wight		Haight	

2- Reporter Data					
Name		Address		Date	
Email		Phone		Relationship with patient	

3- Product Data		
Name of medicine:		Batch No.
How did you get the preparation: □ From the pharmacy with a prescription □ From the pharmacy without a prescription □ From stores other than the pharmacy, specify:		
Purpose of use:	How to take the medicine:	Starting date:
Have you stopped using the medicine? □ Yes □ No Date:	Expiry date:	Dose:

1 -Describe the problem related to the quality or efficacy or side effect of the product, how it was treated, and any other information that you think is necessary including a health condition or any allergy:

Note: If the report on the quality of a product is satisfied with the above data, but if the report is about a side effect, please complete the rest of the form.

4- Data of other used medicine (mention other medicines currently used as well as used in one month before the side effect appears)				
Name of medicine	**Start date**	**End date**	**Dose**	**Purpose of use**

5- Adverse reaction data
Date of adverse reaction appear :
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 …….
Is the side effect removed? □ No □ Yes, date:
The patient □ Recovered, date: □ Recovering □No improvement □Unknown

6- Other information
Has the doctor or pharmacist been informed of these symptoms? □ Yes □ No □ I don't know
If yes, has he completed the Side Effects Report Form? □ Yes □ No □ I don't know
Can we get additional information from your treating doctor? □ Yes □ No □ I don't know
If the answer is yes to the previous point, please provide us with your doctor's contact information: Doctor's name: hospital: phone: