ADVERSE EVENT REPORTING FORM

☐ Adverse Event
☐ Product Issue

Report Date : _____

Patient's Details

Name :

Address :

Date of Birth or Age :

☐ Male
☐ Female

Weight (in Kgs) :

Height (in Feet and Inches) :

Contact Number :
Email Address :

Reporter's Details

Name :

Address :

Reporters Qualification :

☐ Physician
☐ Pharmacist
☐ Non Health Professional

Please specify if none of the above :

_____

Contact Number :
Email Address :

Name of Drug or Brand Name	Batch No. / Lot No.	Dose Taken/ Applied and Frequency	Start Date of Usage	End Date of Usage

Adverse Event Description (Pls share the Diagnosis or Symptoms)	Start Date and End Date of Adverse Event	Intensity Of Adverse Event	Outcome of Adverse Event
		☐ Mild ☐ Moderate ☐ Severe	☐ Ongoing ☐ Recovering ☐ Recovered ☐ Fatal ☐ Unknown
		☐ Mild ☐ Moderate ☐ Severe	☐ Ongoing ☐ Recovering ☐ Recovered ☐ Fatal ☐ Unknown

Please provide any further relevant information about the Adverse Event, any treatment received, investigations carried out.

Signature Of Patient / Reporter

CONFIDENTIAL

Naxpar