INDIAN MEDICAL ASSOCIATION PHARMACO VIGILANCE CELL

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ADVERSE DRUG EVENT REPORTING FORM For VOLUNTARY reporting of Adverse Drugs Events by IMA Members

First Last Age or Date of Birth Sex FO MO Weight kgs Suspected Adverse Event Outcome attributed to adverse event (Check all that apply): Outcome attributed to adverse event (Check all that apply): O Life-threatening O Hospitalization – initial or prolonged D Disability O Congenital anomaly O Required intervention to prevent permanent impairment/damage O Other Dates of event starting (dd/mm/yy) Dates of event stopping (dd/mm/yy) Describe event or problem: Relevant tests/laboratory data, including dates: Other relevant history, including pre-existing medical conditions (eg. Allergies, race, pregnancy, smoking and alcohol use hepatic/renal dysfunction, etc.): Suspected medication(s) 1. Brand and/generic name Labelled strength Manufacturer Dose Frequency Route used Lot # (if known) Exp. Date (if known) Therapy dates: From To Diagnosis for use (separate indications with commas). Event abated after use stopped or dose reduced: Yes O No O Not applicable O Event reappeared after reintroduction: Yes O No O Not applicable O 2. Brand and/generic name Labelled strength Manufacturer Dose Frequency Route used Lot # (if known) Exp. Date (if known) Therapy dates: From To Diagnosis for use (separate indications with commas). Event abated after use stopped or dose reduced: Yes O No O Not applicable O 2. Brand and/generic name Labelled strength Manufacturer Dose Sex Frequency Route used Lot # (if known) Exp. Date (if known) Therapy dates: From To Diagnosis for use (separate indications with commas). Event abated after use stopped or dose reduced: Yes O No O Not applicable O Concomitant medical products and therapy dates including self medication & herbal remedies (exclude those used to tree event) Pincode Tel. No. with STD Code: Specialty Reporter (Sec confidentiality section below) Name and Professional Address Tel. No. with STD Code: Specialty Reporter (Sec confidentiality section below) Also reported to: ONo one else ONanufacturer OUser facility ODistributor If you do not want your identity disclosed to th	Α.	Patient information Patient identifier (initials)						
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