Appendix 1.4 – Adverse Drug Reaction Report Form

CdG Ref No: _____ MAH Ref No.: _____

Date received: _____ Date sent to MAH: _____

Reporter Name: _____ Profession (if HCP): _____

Patient Initials: _____ Age: _____ Male/Female: _____

Suspected Medicine, strength and formulation: _____

Dosage: _____

Batch No.: _____ Expiry Date: _____

Description of ADR: _____

Other medication/s taken by the patient: _____

Patient Medical History:

Did the ADR result in hospitalisation or death? _____ (Please specify)

Additional information (if any) _____

Action/s taken by PV Officer: _____

Follow-up (if any): _____