SUSPECTED ADVERSE DRUG REACTION REPORTING FORM

For VOLUNTARY reporting of Adverse Drug Reactions by healthcare professionals

Themis Medicare Ltd.
11/12, Udyog Nagar Industrial Estate. Sv Road,
Goregaon(W), Mumbai – 400090
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TML ADR 2018…….

A. Patient Information

1.Patient Initials ----------	2.Age at time of Event or date of birth ----------	3.Sex ☐ M ☐ F 4.Weight___Kgs

12. Relevant tests / laboratory data with dates

13. Other relevant history including pre-existing medical conditions (e.g. allergies, race, pregnancy, smoking, alcohol use, hepatic/ renal dysfunction etc)

B .Suspected Adverse Reaction

5. Date of reaction stated (dd/mm/yyyy)

6. Date of recovery (dd/mm/yyyy)

7. Describe reaction or problem

14. Seriousness of the reaction

- ☐ Death (dd/mm/yyy)_____
- ☐ Life threatening
- ☐ Hospitalization-initial or prolonged
- ☐ Disability
- ☐ Congenitial anomaly
- ☐ Required intervention to prevent permanent impairment / damage
- ☐ Other (specify)

15. Outcomes

- ☐ Fatal
- ☐ Recovering
- ☐ Unknown
- ☐ Continuing
- ☐ Recovered
- ☐ Other (specify)_____

C.Suspected medication(s)

S. No	8.Name (brand/ generic)	Manufacturer (if known)	Batch No/ Lot No. (if known)	Exp. Date (if known)	Dose used	Route used	Frequency	Therapy dates (if known give duration)		Reason for use of prescribed for
								Date started	Date stopped	
I.										
II.										
III.										
IV.										

Sl.No As per C	9. Reaction abated after drug stopped or dose reduced					10. Reaction reappeared after reintroduction				
	Yes	No	Unknown	NA	Reduced dose	Yes	No	Unknown	NA	If reintroduced dose
I.										
II.										
III.										
IV.										

11. Concomitant medical product including self medication and herbal remedies with therapy dates (exclude those used to treat reaction)

D. Reporter (see confidentiality section in first page)

16. Name and Professional Address:_____
_____
Pin code : _____E-mail_____
Tel. No. (with STD code): _____
Occupation _____Signature _____

17. Causality Assessment	18. Date of this report (dd/mm/yyyy)