Amarox

SUSPECTED ADVERSE DRUG REACTION REPORT
PHARMACOVIGILANCE FORM

1.Patient Details			
Patient Initials:	Gender: Male ☐ Female ☐	Age:	Additional info:

2.Product Details			
Name of Medicine:	Daily Dose:	Start Date:	End Date:
Indication:	Therapy Duration:	Rout of administration:	

3.Adverse Drug Reaction Details			
Description of Reaction:		Start Date:	End Date:
		Outcomes: ☐ Recovered without sequelae ☐ Recovering ☐ Recovered with sequelae ☐ Unknown/no data	
Seriousness:	☐ Non-Serious		
	☐ Serious	☐ Death ☐ Life-threatening ☐ Hospitalization from to ☐ Hospitalization prolongation from to ☐ Persistent/significant disability/incapacity ☐ Congenital anomaly / Birth defect ☐ Other Medically significant	
Expectedness: ☐ Yes (Expected) ☐ No (Unexpected)			
Dechallenge: ☐Positive (ADR Disappear) ☐Negative (ADR NOT Disappearing after the stopping) ☐ NA Rechallenge: ☐Positive (ADR Reappear) ☐Negative (ADR NOT Reappearing after the Redispensing) ☐ NA			
Adverse Drug Reaction Treatment Required: ☐ Yes ☐ No If Yes please Specify:……			

4.Reporter Details		
Name of the Reporter:	Occupation:	Date of Reporting:
Mobile:	Email:	Signature: