



## GLOBAL FORM

Adverse Drug reaction (ADR) Reporting form for health care professionals (Providers) (HCP)

<b>Suspect Drug Details</b>		
Suspected Drug:	Indication:	Start date (DD/MMM/YY): ____ / ____ / ____
Total daily dose/route:	Batch number:	____ Stop date (DD/MMM/YY): ____ / ____ / ____
<b>Second Suspect Drug Details (if relevant)</b>		
Suspected Drug:	Indication:	Start date (DD/MMM/YY): ____ / ____ / ____
Total daily dose/route:	Batch number:	____ Stop date (DD/MMM/YY): ____ / ____ / ____

<b>Reporter</b>		
Name: _____	Profession: _____	
Institution: _____		
Address: _____		
Tel: _____	Fax: _____	Email: _____

<b>Patient</b>
<i>At least one of the below patient information is needed e.g. gender or age or age group, etc.</i>
Patient Initials: _ _____ Gender: <input type="checkbox"/> F <input type="checkbox"/> M Date of Birth (DD/MMM/YY): ____ / ____ / ____ Age (Y/M/D): __ ____
Height: _____ cm Weight: _ ____ kg Pregnancy: <input type="checkbox"/> no <input type="checkbox"/> yes If yes, pregnancy week: ____

<b>Description of adverse drug reaction(s)</b>	
Continue on separate sheet if more than 2 reactions	
1.	Date of onset (DD/MMM/YY)    ____ / ____ / ____ Time to onset (D/H/MIN)        ____ / ____ / ____ Resolution date (DD/MMM/YY)    ____ / ____ / ____ Causality: Related <input type="checkbox"/> Unrelated <input type="checkbox"/> Unknown <input type="checkbox"/> Did the reaction reappear after reintroduction of drug? Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Not applicable <input type="checkbox"/>



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2.	Date of onset (DD/MMM/YY)    ___ / ___ / ___ Time to onset (D/H/MIN)        ___ / ___ / ___ Resolution date (DD/MMM/YY)   ___ / ___ / ___ Causality   Related <input type="checkbox"/> Unrelated <input type="checkbox"/> Unknown <input type="checkbox"/> Did the reaction reappear after reintroduction of drug? Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Not applicable <input type="checkbox"/>
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<b>Action Taken with suspect drug</b>		
<input type="checkbox"/> Product discontinued due to AE	<input type="checkbox"/> Dose Increased	<input type="checkbox"/> None
<input type="checkbox"/> Dose Decreased	<input type="checkbox"/> Other (please specify):	

<b>Patient's Outcome</b>		
<input type="checkbox"/> Recovered without sequelae	Date (DD/MM/YY)    ___ / ___ / ___	
<input type="checkbox"/> Recovered with sequelae	Date (DD/MM/YY)    ___ / ___ / ___	Specify sequelae _____
<input type="checkbox"/> Ongoing		
<input type="checkbox"/> Improved, but not yet recovered		
<input type="checkbox"/> Death	Date of death (DD/MM/YY)    ___ / ___ / ___	Autopsy: <input type="checkbox"/> yes <input type="checkbox"/> no
<input type="checkbox"/> Unknown		

<b>Seriousness:</b> Was the event serious or non serious? (please indicate below)	
<b>Serious</b> <input type="checkbox"/>	
<input type="checkbox"/> Patient died	<input type="checkbox"/> Initial or prolonged hospitalisation
<input type="checkbox"/> Persistent or significant disability/incapacity	<input type="checkbox"/> Life threatening
<input type="checkbox"/> Congenital anomaly/birth defect	<input type="checkbox"/> Other medically important condition
<input type="checkbox"/> Other reasons (please specify):	
<b>Non Serious</b> <input type="checkbox"/>	

<b>Relevant Medical History</b> (continue on separate sheet if required)	
Concomitant disease(s), pregnancy, relevant laboratory results	Known since (i.e. onset date)
1.	
2.	
3.	

Relevant Concomitant drug(s)/Indication (continue on separate sheet if required)	Total daily dose/route	Start date/Therapy duration
1.		
2.		
3.		



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### Additional Comments

Signature/stamp of reporter: \_\_\_\_\_ Date (DD/MMM/YY):     /     /

### This form can be used by :

- Physician
- Pharmacist
- Dentist
- Nurses
- Other healthcare providers

### How to report:

- Fill out the reporting form.
- Attach additional information, if needed.
- Use a separate form for each product.

### Please submit completed forms to:

Pharmacovigilance Department

Dr.Nabil Khuris-DSO (Drug Safety Officer)

Mr. Mouath Ali Alsaeedi D-DSO(Deputy Drug Safety Officer)

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