REPORTING AN ADVERSE REACTION TO A MEDICINAL PRODUCT

PATIENT:	Initials	Date of birth/age	Sex: F M	Weight
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DESCRIPTION OF ADVERSE SYMPTOMS:	date symptoms first appeared	Classification
	.....	Serious side effects □ – death □ – danger to life □ – permanent or significant disability or impairment □ – hospitalization or an extended period in hospital □ – others that the doctor, based on his knowledge, considers severe
Pregnant - Yes □ No □ If so – week of pregnancy	Outpatient treatment □ Hospital treatment □	Statistical code of cause of death .....

Outcome after discontinuation of drug/medical device

A – recovery without after-effects

B – recovery with after-effects

F – is undergoing treatment

U – unknown

USE OF MEDICINES

Name of the drug	Mark 'P' if the medication is suspected of causing symptoms	Daily Dosage	Route of administration (e.g., oral)	Date you started taking the medicine	Date you stopped taking the medicine	Reason for taking the medication

ADDITIONAL INFORMATION: e.g. previous drug reactions, allergies, other diseases, results of additional tests

DETAILS OF REPORTING PERSON:

Name and surname ..... Specialty …….....

Address .....

Telephone: (.....)..... Fax: .....

Date (day/month/year) ……

Signature ……..……

Adverse reaction – a response to a medicinal product which is noxious and unintended and which occurs at doses normally used in man for the prophylexis, diagnosis or therapy of disease or for restoration, correction or modification of physiological function.