Complete all marked with (*) and give us much other information as you can.

## 1. Patient Details:

| Patient Name/ Initial ………………... | * **Sex** ☐ Male ☐ Female | ☐ Pregnant ☐ Not Pregnant |
|---|---|---|
| * **Age** ……………………... | * **Weight (kg)** ……… | Height (cm)………… |

## 2. Suspected Side Effect (What Happen?)

*** Describe the Side effect(s)**

| |
|---|
| |

How bad was this side effect? (You can choose more than one)

| | |
|---|---|
| ☐ Mild | ☐ Caused serious illness |
| ☐ Effect daily activities | ☐ Caused Death |
| ☐ Admitted to hospital or prolong hospitalization | ☐ Cause Congenital /Birth defect |
| ☐ Other medically important condition: (Please Specify) ………………………………………………………… | |

| Does the side effect go away: | ☐ Yes | ☐ No | Date: |
|---|---|---|---|

| The patient's current condition: | ☐ Fully recovered , Date: | ☐Improving |
|---|---|---|
| | ☐ Not improving | ☐Unkown |

## 3. Suspected Medication:

| * **Medication Name**…………………………….. | | Batch No …………………………… | |
|---|---|---|---|
| Dose (for example: One 500 mg tablet twice a day): ……… …………………………………………… | | | |
| Did you stop because of side effect? | ☐ No | ☐ Yes | Date……………………….. |

## 4. Concomitant Medications and Medical History:

Concomitant Medications (any other Medication that the patient is taking) and Medical History (any chronic diseases that the patient has. For example: Diabetes, Hypertension, etc....

| Concomitant Medications: | Medical History: |
|---|---|
| 1- ………………… | 1- …………………… |
| 2- ………………… | 2- …………………… |
| 3- ………………… | 3- …………………… |
| 4- ………………… | 4- …………………… |
| 5- ………………… | 5- …………………… |

## 5. Other information

Have these symptoms has been reported to your doctor or pharmacist? Yes □ No □ Unkwon □

If yes, did he fill the side effects reporting form? Yes □ No □ Unkwon □

Can we get additional information from your treating physician? Yes □ No □

If the answer is yes, please provide us your doctor's contact information

Doctor's name: hospital: the phone:

## 6. Reporter's Information:

| * **Name** ..................................... | E-mail ................................................ |
|---|---|
| * **Address** .................................... | Phone Number ...................................... |
| Source of information: ☐ Patient ☐ Pharmacist ☐ Doctor ☐ Others ........................ | |

**Confidentiality**: Reporter's and patient's identity are held in strict confidence, information provided by the reporter will be strictly protected and will not be used in any way against him / her.

* After filling the report, please send it to PV@alrazi-pharma.com .