

Document Title:

Adverse Drug Reaction and Adverse Events (English)

Pharmacovigilance

Pharmacovigilance Page No.:										
Complete all marked with	(*) and a	ve us	s much other	information	n as you can					
Complete all marked will	() and g	vo ac	o maon othor	mormado	ir ao you oarr					
1. Patient Details:										
Patient Name/ Initial	*	Sex	☐ Male ☐	Female	□Pregn	ant Not Preg	nant			
T dione reality initial		OUX		romaio	Tregnant Motriegnant					
* ^ ao	*	Waia	ıht (kg)		Lloight (am)					
* Age		weig	jiiι (kg)	•	Height (cm)					
2. Suspected Side Effe	ect (Wha	t Hap	pen?)							
* Describe the Side effect	ct(s)									
	. ,									
How bad was this side effect? (You can choose more than one)										
1 low bad was tills side elle	601: (100	Can	CHOOSE HIGH	e triair one)						
☐ Mild		☐ Cau	☐ Caused serious illness							
☐ Effect daily activities		☐ Caused Death								
_	-									
☐ Admitted to hospital or p	•		zation	☐ Cau	se Congenita	al /Birth defect				
☐ Other medically importar										
(Please Specify)										
Does the side effect go awa	ay:		□ Yes	□ No	Date:					
	- Eully r	- Fully recovered Date.			□Improving					
		Fully recovered , Date:			uniproving					
The patient's current										
condition:	□ Not im	provii	ng	□Unkown						
Condition.										
3. Suspected Medicati	on·									
* Medication Name			T D	latch No						
Dose (for example: One 5										
Did you stop because of s	side effect	?	□ No	☐ Ye	S L	Date				
4. Concomitant Medica	ations ar	nd Me	edical Histor	rv:						
Concomitant Medications					is taking) an	d Medical Hist	ory (any			
Correctinitarit Wedicatione	(arry our		diodilon indi	tilo pationi	io taking, an	a modical inc	ory (arry			
chronic diseases that the	patient ha	as. Fo	or example: [Diabetes, H	ypertension,	etc				
			•	,	,					
Concernitent Medications				Madiaalii	iotonu		·,			
Concomitant Medications:		Medical History:								
1		1								
2				2						
3				3						
4				4						
5				5						
1				1			l l			



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5. Other information									
Have these symptoms has been reported to your opharmacist?	Joctor or	Yes □	No □	Unkwon □					
If yes, did he fill the side effects reporting form?		Yes □	No □	Unkwon □					
Can we get additional information from your treating	ng 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	E-mail							
* Address	Phone N	Phone Number							
Source of information: Patient Pharma	acist	or 🔲 Ot	thers						
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.