

ADVERSE DRUG REACTION REPORTING FORM

ADVERSE REACTION INFORMATION				
1. NAME & LOCATION	2. AGE YRS	3. SEX	4. MEDICAL RECORD #	5. DIAGNOSIS
			6. DATE/TIME	7. ATTENDING MD
7. TYPE OF REACTION: INTERVENTION FOR REACTION: (Continue on the back if necessary)			8. Check all appropriate <input type="checkbox"/> Patient expired <input type="checkbox"/> Reaction treated with Rx drug <input type="checkbox"/> Resulted in, or prolonged, inpatient hospitalization <input type="checkbox"/> None of the above 9. Did reaction abate after stopping the drug? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/A 10. Did reaction reappear after reintroduction? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/A	
11. RELEVANT TESTS/LABORATORY DATA				
SUSPECTED DRUG(S) INFORMATION				
12. SUSPECTED DRUG(S) Give manufacturer and lot number for vaccine/biologics			16. DATES OF ADMINISTRATION	
13. DOSE AND FREQUENCY	14. ROUTE OF ADMINISTRATION		17. DURATION OF ADMINISTRATION	
15. INDICATION(S) FOR USE				
CONCOMITANT DRUG HISTORY				
18. CONCOMITANT DRUGS AND DATES OF ADMINISTRATION (Exclude those used to treat the reaction)				
PAST MEDICAL HISTORY				
19. INDICATE RELEVANT PAST MEDICAL HISTORY				
20. DRUG ALLERGIES & SIDE EFFECTS (Please indicate the type of reaction for each drug)				
21. REPORTER'S SIGNATURE			DATE	

