Mohammed Mahdi Al-Shaer Corporation

AL SHAER CORP
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مؤسسة محمد مهدي الشاعر

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Adverse Drug Reaction Reporting Form

1. Patient Details:

Patient Name/ Initial: ………………… **Sex:** ☐ **Male** ☐ **Female ,** **Pregnant** ☐ **Yes** ☐ **No**

Age: ……………… **Hight:** ……………….. **Weight:** ………………………

2. Describe the Side effect(s)

……
……
……
……
……
……
……

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

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

3. Suspected Medication Information:

Medication/s Name:
1.
2.

Reason for use:
Dose and Strength:
Start Date: / /

Did the patient stop because of side effect? ☐ **No** ☐**Yes , Date / /**

Comments (eg: relevant history, allergies, previous exposure to the drugs………etc.
……
……
……
……
……

Did reaction(s) disappear after discontinuation of suspected drugs(s)?
☐ Yes ☐ No ☐ Unknown

4. Concomitant Medications (any other Medication that the patient is taking) and Medical History (any chronic diseases that the patient has)

Concomitant Medications:	Medical History:
1. ……………………	**1.** ……………………
2. ……………………	**2.** ……………………
3. ……………………	**3.** ……………………
4. ……………………	**4.** ……………………

5. Reporter's Information:

Name:	**,Status : □ Physician □ Dentist □ Pharmacist Other,………**
Address:	**Mobile Number:**
E-mail:	**Date: / /**
Signature:	

Please send this report to:
Pv@alshaercorp.com