Adverse Drug Reaction Report

(NB: Identities of Reporter, Patient & Institution will be kept confidential.)

Patient's Name :

Age : Sex : Race : Weight :

Drug's Name :

Dose : Date Started : Date Stopped :

For which reason the drug was used :

Other drugs used before or at the same time

Name	Dose	Date Started	Date Stopped	Reason for use

Adverse Reactions

Description :	Date of onset :

Treatment of Reaction:

Recovery YES Date of Recovery Not Yet ☐ Unknown ☐

Fatal YES Date of Death

Sequelae

Others

Reporting Doctor / Pharmacist

Name :

Address :

Institution :

Date Signature

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