

ADVERSE REACTION REPORT FORM

IN CONFIDENCE

(FOR COMPLETION BY HEALTHCARE PROFESSIONALS)

PLEASE SEND TO:-
 FREEPOST
 PHARMACOVIGILANCE UNIT
 IRISH MEDICINES BOARD
 EARLSFORT CENTRE
 EARLSFORT TERRACE
 DUBLIN 2

REPORTER'S NAME & ADDRESS:

Telephone: 353-1-6764971
 Fax: 353-1-6762517
 E-mail: imbpharmacovigilance@imb.ie

AREA OF SPECIALITY:

Patient Initials/Record No:		Sex: M F	
Age:		Weight (if known):	Ethnic Origin:
Indication for Use:			
Suspect Drug/Vaccine: <small>Please use brand names where possible</small>	Daily dose	Route	Batch No.
Dates of Treatment			
Suspected Reaction: (Brief description of the toxic effects or side effects)			
Onset of Reaction: (Date)		Duration of Reaction:	
Any other drugs used over this period? (Please state below)			
Drug	Daily Dose	Indication for Use:	
Recovery from Side Effects: Complete Symptoms Continuing Fatal <i>(Please circle)</i>			
If treatment was required please specify:			
Drug Discontinued: Y N		Drug Rechallenge: Y N	
Improvement on discontinuation Y N			
Supply of Report Cards Required: Y N		Manufacturer Notified: Y N	

Signature: _____

Date: _____

Thank you for taking the time to complete this form