SUSPECTED ADVERSE DRUG REACTION REPORTING FORM

For VOLUNTARY reporting of Adverse Drug Reactions by Healthcare Professionals

A. PATIENT INFORMATION

1. Patient Initials*:	**3.** Gender: □ M □ F □ O
2. Age at the Time of Event or Date of Birth*:	**4.** Weight: _____ Kgs.

B. SUSPECTED ADVERSE REACTION

5. Event/Reaction Start Date* (dd/mm/yyyy):	**6.** Event/Reaction Stop Date (dd/mm/yyyy):	**6 (i).** Onset Lag Time: _____ hr. _____ min.
7. Describe Event/Reaction with Treatment Details, if any*:		

C. SUSPECTED MEDICATION(S)

Sr. no	**8.** Name* (Brand/ Generic)	Mfg/Mkg by (if Known)	Batch No. / Lot No.	Exp. Date	Dose Used	Route Used	Frequency (OD, BD etc.)	Therapy Dates		Indication	Causality Assessment
								Date Started	Date Stopped		
i											□ Certainly □ Probably □ Possibly □ Unlikely □ Conditional □ Unassessable
ii											
iii											

Sr. No	**9.** Action Taken (please tick)						**10**. Reaction Reappeared after Re-introduction (please tick)				
	Drug Withdrawn	Dose Increased	Dose Reduced	Dose Not Changed	Not Applicable	Unknown	Yes	No	Unknown	NA	Dose (if re-introduced)
i											
ii											

11. Concomitant Medications (exclude those used to treat reaction)

Sr. No	Name (Brand/Generic)	Dose Used	Route Used	Frequency (OD, BD etc.)	Therapy Dates		Indication
					Date Started	Date Stopped	
i							
ii							
iii							

12. Relevant Tests/Laboratory Data with Dates:

13. Relevant Medical/Medication History (E.g. Allergies, Race, Pregnancy, Smoking, Alcohol Use, Hepatic/Renal Impairment, Past Surgery etc.):	**14.** Seriousness of the Reaction: □ No if □ Yes (please tick anyone) □ Death (dd/mm/yyyy) □ Congenital-anomaly □ Disability □ Hospitalization/ Prolonged □ Life Threatening □ Other Medically Important	**15.** Outcomes (please tick) □ Recovered □ Recovering □ Not Recovered □ Fatal □ Recovered with Sequelae □ Unknown
Additional Information, if any:		

D. REPORTER DETAILS*

16. Name and Address:

Contact No: E-mail:

Qualification/Occupation: Signature:

17. Date of this Report (dd/mm/yyyy):

E. FOR OFFICE USE ONLY

Report Received on:

ADR Report No:

Name and Signature of Receiver:

After completing, submit this form to the sales representative of Blue Cross **OR** Send the report by post/email to:

BLUE CROSS LABORATORIES PVT LTD. Medical Services Department, Peninsula Chambers, G.K. Marg, Lower Parel, Mumbai 400013.

Email: drugsafety@bluecrosslabs.com | **Website**: www.bluecrosslabs.com | **Toll Free No.**: 1800 123 6385.

- **Confidentiality: The patient's as well as reporter's identity is held in strict confidence and protected to the fullest extent.**
- **Submission of a report does not constitute an admission that medical personnel or manufacturer or the product caused or contributed to the reaction.**
- **Submission of an ADR report does not have any legal implication on the reporter.**

Instructions for filling this form are available on our website under 'Pharmacovigilance' section. If required, you may refer the same.

*Mandatory fields required to be filled by the reporter.

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