الشركة الدوائية الحديثة
MODERN PHARMA

Adverse Drug Reactions (ADRs)Reporting Form
For Health Care Professionals (ADR-1)

A. Patient Details

Patient name or initial (Optional):	Date of birth:	Height:	Weight:	Health Institution:	Age:	Sex: M F

B. Suspected Drug(s

		Drug name"Generic &Brand"	Dose / Route / Frequency	Start date	End date	Purpose of use
Suspected	1					
	2					
	3					
Concomitant	1					
	2					
	3					

C. Adverse Drug Reaction

Adverse event including relevant tests/lab data and dates	Other relevant history, including preexisting medical conditions *(diagnosis, allergies, pregnancy, hepatic, renal etc.)*
Date of event started:	Date of event disappeared, if applicable:

D. Action Taken

Drug withdrawn. ☐ Dose reduced. ☐ Dose increased. ☐ Dose not changed. ☐ Unknown. ☐ Not applicable. ☐

E. Outcome of ADR (Tick all applicable)

The patient	☐ Recovered, date:	☐ Recovering	☐ No improvement	☐ Fatal ☐ Unknown
Event subsided after stopping (dechallenge)			☐ No	☐ Yes ☐ Unknown
Event reappear after reintroducing (rechallenge)			☐ No	☐ Yes ☐ Not applicable
Specific antagonist or treatment used:			☐ No	☐ Yes, specify:

F. Seriousness of ADR (Tick all applicable)

☐ Patient died, date:	☐ Life threatening	☐ Permanent disability
☐ Hospitalization	☐ Prolonged hospitalization more than 24 hr.	☐ Congenital anomaly
☐ Required intervention to prevent permanent impairment/ damage		☐ Required Emergency Room (ER) visit
☐ Cancer	☐ Others	

G. Reporter Details

Reporter name:		Profession (Specialty):	
Address:		E-mail:	
Phone / Mobile:	Fax:	Date:	Signature:

info@modernpharmaye.com
www.modernpharmaye.com