ADR Report Number: _____

Complaint Report Number: _____

ADVERSE DRUG REACTION FORM

ADR Report Received By: _____

Date Received: _____

Method of Notification: _____

Section A – Source Information

Name of Reporter:	
Position/Relation to Patient	
Medical Facility:	
Address:	
Telephone and Fax Numbers:	
Email Address:	
Primary Language:	

Section B – Product Details

Product Name/Strength/Size:	
Dosage and Route of Admin:	
Lot Number and Expiry Date:	

Section C – Patient Details

Patient Name	
Date of Reaction	
Date Treated	
Brief Description of Reaction (Including outcome and disposition of product if known)	

Report Completed By: _____

Qualified Health Care Professional / Date

Report Forwarded to MAH by e-mail/fax (circle one) on: _____

Date