ADVERSE EVENT REPORT FORM

Date of reporting			
What would you like to share?	☐ Adverse Event / Side effect ☐ Product Quality Complaint ☐ Seeking Information	**Is the female patient pregnant?**	☐ Yes ☐ No ☐ Not Applicable (male patient)

Reporter (your) details	**Patient/consumer details**	**Your role as a reporter**
Name: Address: Tel #	Initials: Gender: ☐ Male ☐ Female ☐ Unknown Date of Birth/Age: Weight: Height: Ethnicity:	☐ Patient / Consumer ☐ Physician ☐ Pharmacist ☐ Nurse ☐ Relative (specify below) ☐ Friend of patient ☐ Others (specify below)

Name of the Medicine & package details	**Prescribed dose**	**Indication**	**Batch No**	**Exp Date**

Treatment start date	
Is the treatment continuing?	☐ Yes ☐ No ☐ Unknown
Treatment stop date (if 'No' above)	

Describe the experience during the treatment in detail:

Adverse Events Details	**Start Date**	**Resolved?**	**Stop Date (if resolved)**
1. 2. 3. 4. 5.		☐ Yes ☐ No ☐ Uknown ☐ Yes ☐ No ☐ Uknown ☐ Yes ☐ No ☐ Uknown ☐ Yes ☐ No ☐ Uknown ☐ Yes ☐ No ☐ Uknown	

Did the event resolve after the treatment stopped?	☐ Yes ☐ No ☐ Not Applicable
Did the event reappear after restarting the medicine?	☐ Yes ☐ No ☐ Not Applicable

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How was the adverse event treated?

Medical History/ Pre-existing conditions / Allergy/ Smoking/ Alcohol consumption	Start Date	Still continuing	Stop Date
1. 2. 3. 4. 5.		☐ Yes ☐ No ☐ Uknown ☐ Yes ☐ No ☐ Uknown ☐ Yes ☐ No ☐ Uknown ☐ Yes ☐ No ☐ Uknown ☐ Yes ☐ No ☐ Uknown	

Other medicines taken during the current treatment	Dosage and route	Indication	Start Date	Stop date / still continuing?
1. 2. 3. 4. 5.				

Blood work / Lab work done	Values	Ref range	Observation/Conclusion
1. 2. 3.			

Check any of the below that occurred during/after the treatment

- ☐ Death
- ☐ Life threatening condition
- ☐ Permanent disability
- ☐ Congenital anomaly (birth defect)
- ☐ Hospitalization for 24 hrs
- ☐ Serious condition as described by the physician
- ☐ Surgery required due to adverse event

Is product available for investigation? (for product quality complaints only)

☐ Yes ☐ No

Are you comfortable Pruvia Healthcare following-up with treating physician for more details?

☐ Yes ☐ No

Treating physician's name and contact details:	Pharmacy/pharmacist name and contact details

Reporter's signature with date	Additional Comments