Adverse Side Reaction (ASR) Reporting Form

VIECO

DATE OF EVENT

REPORTER DETAILS

Full Name

Phone Number

(xxx) xxx-xxx-xxx

Email Id

Organisation

Address

Country

City

Post Code

Address 1

Address 2 (Optional)

PATIENT INFORMATION (ASR)

Name

Gender

Male Female

Weight

In Kilogram (KG) :

Height

In Centimeter (CM) :

Date Of Birth

Country

Description of Event (according to the reaction side and date the reaction started and ended)

Is The ASR Serious

☐ Yes ☐ No

If Yes, Reason For Seriousness

☐ Death Date

☐ Life - threatening ☐ Disability ☐ Hospitalisation - initial

☐ Congenital abnormality ☐ Hospitalisation - prolonged ☐ Others

If Others, Please Specify

OUTCOME OF THE ASR

☐ Resolved ☐ Lost to follow-up

☐ Unknown ☐ Death Date

Autopsy Planned / Done

☐ Yes ☐ No

Autopsy Report Available

☐ Yes ☐ No

SUSPECTED MEDICATION

Drug Name

Generic Name

Daily Dose & Route

Start Date End Date

Indication

CONCOMITANT MEDICATION(S)

DRUG NAME

GENERIC NAME

DAILY DOSE & ROUTE

Start Date

End Date

Indication

ACTION TAKEN TO TREAT ASR

- [ ] Medical Treatment

Specify

- [ ] Drug Stopped
- [ ] Drug Reduced

Specify

Did the ASR subside after stopping the suspected medication

- [ ] Yes
- [ ] No

MEDICAL HISTORY

Condition

Onset

Details

Present

- [ ] Yes
- [ ] No

LABORATORY DATA

Drug Name

Start Date

Results

ADDITIONAL INFORMATION