





## ADVERSE DRUG REACTION (ADR)/PRODUCT QUALITY PROBLEM REPORT FORM (WESTERN CAPE PUBLIC SECTOR) (Including Herbal Products)

Reporting Healt	Reporting Health Care Facility/Practice																
Tel: (021) 406 6829 Facility/Practice																	
Fax: (021) 4	<b>448 0503</b> District										Tel						
E-mail: pha-m	mic@uct.ac.za Province										Fax						
Patient Details											I ax						
Patient Initials File/Reference Number										Date	of Birth	/Age					
Sex							eight (kg) Height (cm)					Pregnant? □ N □ Y					
Allergies		rtao	<u> </u>			mated Ges	station	nal Age		, ,	tion		1 Togridi				
	N DV DI	nt CE							of TE	 	TD						
RVD positive:  Suspect Medicin		71 IIX	eline CD4:						☐ Y				3: DS-		☐ DR-T	<u> </u>	
Trade Name [Generic Name if		f	Route Dose (mg) and		Date					ason for use		Batch		Expi			
Trade Name is unknown]			Interval			Started/Given		Date Glopped The				Num	mber Date		e		
Adverse Drug R			Problem										ı				
Date and time of onset of reaction  Date reaction resolved/duration																	
Please describe Adverse Reaction/Product Quality Problem: (kindly add as much clinical information as possible)																	
Intervention/tiel	call that anniv	Deticut Outcomes (tick all that annies)															
Intervention(tick all that apply)						Patient Outcomes (tick all that apply)											
□ No intervention						□ ADR recovered/resolved □ recovering/resolving											
☐ Intervention unknown						□ Not recovered/not resolved											
☐ Patient Counselled/non-medical treatment						☐ Patient Died: Date of death: ☐ Impairment/Disability ☐ Congenital Anomaly											
□ Discontinued Suspect Drug; Replaced with:						☐ Patient Hospitalised or Hospitalisation prolonged											
□ Decreased Suspect Drug Dosage; New Dose:						☐ Life Threatening ☐ Other:											
☐ Treated ADR - with:																	
Referred to Hospital: Hospital Name  Other Intervention (e.g., dialycis):						□ ADR reappeared after restarting suspect drug/similar drug											
☐ Other Intervention (e.g., dialysis):							(rechallenge)? □ N □ Y □ Not done □ Unknown  Additional Laboratory Results										
Lab Test Result		Result	Test Da		te	Lab Test		Te		Test Re	sult	Test Date					
Co-morbidities/Other Medical Condition(s)																	
Reported by:						E-mail											
Name	otion DN						<b>-</b> .	!									
Designation								ephone	=								
Date reported  THIS ADR REPO	R OR THI	_	nature	r MEDIC	INF(S)	CALISE	D THE	ΔDR		V1.1 09/	22						
THE COLUMN		II (1417			L			JVI		(0)							