CONFIDENTIAL

REPUBLIC OF UGANDA
MINISTRY OF HEALTH

SUSPECTED ADVERSE DRUG REACTION REPORTING FORM

A. PATIENT DETAILS

Patient name	Patient Number	Sex: M/F*
Age at time of onset(yrs)*	Health Facility	Last Menstrual Period
Weight (kg)	District	Trimester (if pregnant)

B. SUSPECTED DRUG (S) DETAILS

Generic Name*	Brand Name	Dose ,Route Frequency	Date* started	Date stopped	Prescribed for	Expiry date	Batch No

C. SUSPECTED REACTIONS

Please describe the reaction as observed and any treatment given to manage the reaction

Outcome

Recovered ☐ Recovering ☐ Continuing ☐ Death due to reaction ☐

Date reaction started*	Date reaction stopped	Date of notification

SERIOUSNESS OF THE REACTION

Patient died ☐ Prolonged inpatient Hospitalization ☐ Involved disability ☐ Life Threatening ☐
Congenital abnormality ☐

D. CONCOMITANT DRUGS

Please give information on the drug(s) the patient has been taking together with the suspected drug including those taken for chronic diseases (include self medication and herbal preparations)

Generic	Name Brand	Dosage	Date started	Date stopped	Indication(prescribed or OTC)

Relevant laboratory tests including dates	**Additional relevant information (medical history, allergies, failure of efficacy)**

E. REPORTER'S DETAILS

Name/designation*	Telephone and Email Address	Date of reporting	Health facility

* Mandatory field