MEDICINES SIDE EFFECT / ADVERSE EFFECT REPORTING FORM (FOR CONSUMERS)

PHARMACOVIGILANCE CELL
(Pharmaleaf India Private Limited, 2nd Floor, Daarul Awkaf, 6, Cunningham Road, Bangalore -560052, India)

1.Patient Details

Patient Initials:	Gender (√): Male ☐ Female ☐ Other ☐	Age (Year or Month):

2. Health Information

a. Reason(s) for taking medicine(s)(Disease/Symptoms):

b. Medicines Advised by (√): Doctor ☐ Pharmacist ☐ Friends/Relatives ☐ Self (Past disease experienced/No past disease experienced) ☐

3. Details of Person Reporting the Side Effect

Name (Optional):

Address:

Telephone No:	Email:

4. Details of Medicine Taking/Taken

Name of Medicines	Quantity of Medicines taken(e.g. 250 mg, Two times a day)	Expiry Date of Medicines	Date of Start of Medicines	Date of Stop of Medicines

Dosage form (√): Tablet ☐ Capsule ☐ Injection ☐ Oral Liquids ☐ If Others (**Please Specify** _____)

5. About the Side Effect

When did the side effect started (dd/mm/yyyy)? Side Effect Continuing (Yes/No):

When did the side effect stopped (dd/mm/yyyy)?

6.How bad was the Side Effect? (Please √ the boxes that Apply)

☐ Did not affect daily activities	☐ Affect daily activities
☐ Admitted to hospital	☐ Death

☐ Others (Please Specify _____)

7.Describe the Side Effect (What did you do to manage the side effect?)

The information provided in this form will be forwarded to ADR Monitoring Centre for follow-up. You are requested to cooperate with the programme officials when they contact you for more details. Please do report if you do not have all the information.

Send your report by mail or Fax to	
PHARMACOVIGILANCE CELL **PHARMALEAF INDIA PRIVATE LIMITED** 2nd Floor, Daarul Awkaf, 6, Cunningham Road, Bangalore -560052, India Fax: 080-22285733 E Mail:pvcell@pharmaleaf.com Website: www.pharmaleaf.com	 **Call us on Helpline** **080-22285733/ 22342087 (24*7)**
Confidentiality: The patient's identity is held in strict confidence and protected to the fullest extent. Programme staff is not expected to and will not disclose the reporter's identity in response to a request from the public.	

Instructions to Complete the Form

Section 1 - Patient Details

- ✓ In patient Initial, write first letter of the name and first letter of the surname (e.g. Pradeep Sharma-PS).
- ✓ Provide personal information (Gender, Age).

Section -2 Health Information

- ✓ Provide reason(s) for taking medicines and medicines advised by (Doctor, Pharmacists, Friends/ Relatives and Self).

Section 3 - Details of Person Reporting the Side Effect

- ✓ Provide the name (optional), address; telephone no. and email are necessary to assess the report.

Section 4 - Details of the Medicines Taking/Taken

- ✓ Give all details about the Medicines (Name of Medicines, Quantity of Medicines taken, Expiry Date, start and stop date of Medicines) that have caused side effect.
- ✓ Please provide Dosage form (Tablets, Capsule, injections, Oral liquid) and if others please specify.

Section 5 - About the Side Effect

- ✓ Provide Side effect start and stop dates and also specify whether the side effect continuing.

Section 6 - How bad was the Side Effect

- ✓ Please tick marks the appropriate boxes that apply.

Section 7- Describe the Side Effect

- ✓ Please describe the details of side effect and what treatment taken to manage side effect.