CENTRAL RESEARCH INSTITUTE, KASAULI (H.P) - 173204
Under Directorate General of Health Services,
Ministry of Health & Family Welfare, Govt. of India.

सत्यमेव जयते

ADVERSE DRUG REACTION REPORTING FORM

Sr. No._____

1. PARTICULARS OF PATIENT :

Patient's Initials _____ Age_____ Sex_____ Weight _____

Relevant Medical History _____

_____

2. ADVERSE EVENT :

Reason for reporting:

☐ Requires or prolongs hospitalization ☐ Life threatening ☐ Death

☐ Permanently disabling or incapacitating ☐ Congenital anomaly ☐ Overdose

☐ Other (Please Specify):_____

3. SUSPECTED IMMUNOBIOLOGICAL (VACCINE/ANTISERA) :

Name of the product: _____ Batch No. :_____

Date of Manufacturing: _____ Date of Expiry: _____

Date of Administration: _____ Route of Administration: _____

Date of Occurrence of Adverse Event: _____

Nature of Event: _____

_____

Medication given (if any) :_____

4. REPORTING PERSONNEL (DOCTORS / PHARMACISTS / NURSES/PATIENT) INFORMATION:

Name: _____ Occupation: _____

Address: _____

Email: _____ Phone: _____

Dated Signature of Reporting Personnel: _____