

CIOMS FORM

SUSPECT ADVERSE REACTION REPORT												

I. REACTION INFORMATION

1. PATIENT INITIALS (first, last)	1a. COUNTRY	2. DATE OF BIRTH			2a. AGE	3. SEX	4-6 REACTION ONSET			8-12 CHECK ALL APPROPRIATE TO ADVERSE REACTION
		Day	Month	Year	Years		Day	Month	Year	
7 + 13 DESCRIBE REACTION(S) (including relevant tests/lab data)										<input type="checkbox"/> PATIENT DIED <input type="checkbox"/> INVOLVED OR PROLONGED INPATIENT HOSPITALISATION <input type="checkbox"/> INVOLVED PERSISTENCE OR SIGNIFICANT DISABILITY OR INCAPACITY <input type="checkbox"/> LIFE THREATENING
RF 06_2555										

II. SUSPECT DRUG(S) INFORMATION

14. SUSPECT DRUG(S) (include generic name)		20. DID REACTION ABATE AFTER STOPPING DRUG? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA
15. DAILY DOSE(S)	16. ROUTE(S) OF ADMINISTRATION	21. DID REACTION REAPPEAR AFTER REINTRODUCTION? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA
17. INDICATION(S) FOR USE		
18. THERAPY DATES (from/to)	19. THERAPY DURATION	

III. CONCOMITANT DRUG(S) AND HISTORY

22. CONCOMITANT DRUG(S) AND DATES OF ADMINISTRATION (exclude those used to treat reaction)
23. OTHER RELEVANT HISTORY (e.g. diagnostics, allergics, pregnancy with last month of period, etc.)

IV. MANUFACTURER INFORMATION

24a. NAME AND ADDRESS OF MANUFACTURER	
	24b. MFR CONTROL NO.
24c. DATE RECEIVED BY MANUFACTURER	24d. REPORT SOURCE <input type="checkbox"/> STUDY <input type="checkbox"/> LITERATURE <input type="checkbox"/> HEALTH PROFESSIONAL
DATE OF THIS REPORT	25a. REPORT TYPE <input type="checkbox"/> INITIAL <input type="checkbox"/> FOLLOWUP