



Drug Safety Monitoring Programme, Pharmacy Board of Sierra Leone, Ministry of Health and Sanitation.
PATIENT/CONSUMER REPORTING FORM FOR SUSPECTED ADVERSE DRUG REACTIONS

1. PATIENT DETAILS

*.Patient's name:		Address:	
*.Sex:	*.Age(months/years):	Height:(cm)	Weight:(kg)
Health Facility			

2. DETAILS OF DRUGS

*.Name:		*.Strength:	
*.Daily Dose:	*.Start date:	End date:	
Therapeutic indication:		Route of administration:	
Name and Address of Manufacturer:			

3. DETAILS OF ADVERSE EVENTS

*.Description of reaction experienced by patient:

*.Date/time reaction started	Date/time reaction stopped	Was patient admitted <input type="checkbox"/> Yes <input type="checkbox"/> No	Duration of admission (hours/days)
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4. DRUGS TAKEN CONCOMITANTLY /IN THE LAST 3 MONTHS PRIOR TO THE REACTION.
All concomitant drugs including self- medication and herbal preparations

Brand or Generic Name:	Daily dose	Route of Administration	Date started	Date Stopped	Reasons for Use

Action taken	Outcome	Treatment of reaction
<input type="checkbox"/> Drug withdrawn	<input type="checkbox"/> Recovering/resolving	
<input type="checkbox"/> Dose increased	<input type="checkbox"/> Recovered/resolved	
<input type="checkbox"/> Dose reduced	<input type="checkbox"/> Recovered with sequelae	
<input type="checkbox"/> Dose not changed	<input type="checkbox"/> Not recovered	
<input type="checkbox"/> Unknown		

5. *.REPORTER DETAILS

Name:	
Designation:	
Date:	Telephone No:

Note: Fields marked (*) are mandatory