



Pharmacovigilance Department
ADVERSE EVENT REPORTING FORM

Type of Report: <input type="checkbox"/> Initial case <input type="checkbox"/> Follow up										
(A) Patient Details*										
Patient Initials		_____ [ex. Vishal Kumar Sharma <u>VKS</u>]				Country				
Age/ Date of Birth						Weight				
Gender		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other				Pregnant		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
(B) Suspected Medication(s) *										
S. No.	Product Name		Manufacturer name	Marketer Name	Batch number/ Expiry Date	Dose, Route & Frequency (OD/BD etc.)	Therapy Start date <small>DD/MM/YYYY</small>	Therapy Stop date <small>DD/MM/YYYY</small>	Indication	# Action Taken
	Brand Name	Generic Name with strength/ formulation								
1.										
2.										
3.										
# Select appropriate action taken: Drug Withdrawn; Dose reduced; Dose increased; Does not changed; Unknown; Not applicable										
Did event abated after drug withdrawn/ dose reduced? <input type="checkbox"/> Yes / <input type="checkbox"/> No / <input type="checkbox"/> Unknown / <input type="checkbox"/> Not applicable					Did event reappeared after reintroduction? <input type="checkbox"/> Yes / <input type="checkbox"/> No / <input type="checkbox"/> Unknown / <input type="checkbox"/> Not applicable					
Concomitant medications (Any other medications consumed along with our company drugs):										
Drug Name	Dose & Frequency	Route	Therapy dates		Reason for use					
			From	To						
(C) Adverse Event Details *										
Adverse event	Date of event Onset	Date of event stopped	##Outcome							
## Select outcome of the event: <i>Recovering; Recovered; Not Recovered; Recovered with sequelae; Unknown; Fatal</i>										
Is the adverse event serious? <input type="checkbox"/> Yes / <input type="checkbox"/> No If yes, please indicate why it is serious? (Check all that apply)										
<input type="checkbox"/> Death			<input type="checkbox"/> Life threatening			<input type="checkbox"/> Hospitalization-Initial /Prolonged				
<input type="checkbox"/> Congenital anomaly/birth defect			<input type="checkbox"/> Disability			<input type="checkbox"/> Other important medical event				

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If hospitalized provide: Date of admission _____ Date of discharge _____ Attach the copy of discharge summary with this form.	If Death provide: Date of death <small>DD/MM/YYYY</small> _____ Cause of death _____ Autopsy: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Autopsy result (If yes): _____
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Description of adverse events: (including sign and symptoms with specific diagnosis, treatment):

Relevant Lab test Details (with dates, results and normal range):

Other relevant history including pre-existing medical conditions: (e.g. allergies, smoking, alcohol use, liver/kidney problems etc.)

(D) Reporter details*

Name:	Occupation:
Email:	Phone No.
Address:	Date of this report:

Consent to contact Healthcare Professional (HCP) / Prescribing Physician: Yes No

If yes, provide contact Healthcare Professional (HCP) / Prescribing Physician details

Name:	Qualification:
Address:	
Email:	Phone No.

** Mandatory Fields for Adverse Event Reporting Form.*

Please send the complete form to:
 Registered office: -
UNIMARCK HEALTHCARE LIMITED, S-49, 1ST FLOOR JANTA MARKET, RAJAURI GARDEN, NEW DELHI, 110027
 or email the scanned copy to: Email id: complaints@uhlpharma.co.in
 If any additional data, then please attach with this form:

This section filled by Unimarck Healthcare Limited only:

Report ID: _____	Receipt Date: _____
Name and signature of receiving PV-personnel: _____	