KRM Ayurveda Pvt. Ltd.

77 Tarun Enclave, Parwana Road, Pitam Pura, Delhi, Delhi 110034

ADR FORM

(Adverse Drug Reaction)

SUSPECTED ADVERSE DRUG REACTION REPORTING FORM

For VOLUNTARY reporting of Adverse Drug Reactions by health care professionals

Report #

To be filled in by Pharmacovigillance centres receiving the form.

A. Patient information

1. Patient identifier initials _____ In confidence
2. Age at time of event: or _____ Date of Birth:
3. Sex ☐ M ☐ F
4. Weight_____ Kgs

B. Suspected Adverse Reaction

5. Date of reaction started (dd/mm/yy):
6. Date of recovery (dd/mm/yy):
7. Describe reaction or problem

12. Relevant tests/ laboratory data, including dates

13. Other relevant history, including pre-existing medical conditions (e.g., allergies, race, pregnancy, smoking alcohol use, hepatic/ renal dysfunction, etc.)

14. Seriousness of the reaction
- ☐ Death (dd/mm/yy)_____
- ☐ Life threatening
- ☐ Hospitalization-initial or prolonged
- ☐ Disability
- ☐ Congenital anomaly
- ☐ Required intervention to prevent permanent impairment/ damage
- ☐ Other (specify)_____

15. Outcomes
- ☐ Fatal
- ☐ Continuing
- ☐ Recovering
- ☐ Recovered
- ☐ Unknown
- ☐ Other (specify)_____

C. Suspected medication(s)

Sl. No.	8. Name (brand and / or generic name)	Manufac-turer (If known)	Batch No. / Lot No. (If known)	Exp. Date (If known)	Dose used	Route used	Frequency	Therapy dates (if unknown, give duration)		Reason for Use or prescribed for
								Date started	Date stopped	
i										
ii										
iii										
iv										

Sl. No. As per C	9. Reaction abated after drug stopped or dose reduced					10. Reaction reappeared after reintroduction				
	Yes	No	Unknown	NA	Reduced dose	Yes	No	Unknown	NA	If reintroduced, dose
i										
ii										
iii										
iv										

11. Concomitant medical products and therapy dates including self medication and herbal remedies (exclude those used to treat reaction)

D. Reporter (see confidentiality section in first page)

16. Name and Professional Address: _____

Pin code: _____ E-mail: _____

Cell No. / Tel. No. with STD Code: _____

Speciality: _____ Signature:

17. Occupation

18. Date of this report