

LOGO CENTRE NAME CENTRE ADDRESS		
	Adverse Drug Reaction Event	Date of Issue : 01/06/2021 Issue No. : JSL/I//01 Date of Revision: 31/05/2022 Revision No. : 00

SERVICE NAME :	ADVERSE DRUG REACTION EVENT
DATE CREATED :	01/06/2021
APPROVED BY :	DOCTOR NAME
REVIEWED BY :	DOCTOR NAME

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A. Purpose:

To provide guideline instruction for monitoring adverse drug reaction event and ensure its proper reporting.

A. **Scope:** Hospital wide

B. Protocol:

In case of any drug reaction / adverse reaction actions taken are as follows:

1. The person noticing the reaction i.e. Doctor / Patient immediately informs the concerned doctor and clinical management is initiated then & there.
2. The Doctor informs in charge pharmacy & Main Medicine store.
3. The ADR [Adverse drug reaction] form is filled up by the concerned doctor
4. Drug responsible for adverse reaction is identified.
5. Batch of the drug identified.
6. All Patient rooms & areas where the drug has been issued are advised NOT to use the drug of that particular batch.
7. Information regarding any such similar reactions anywhere in the hospital is gathered and documented and forwarded to the Medical Superintendent.
8. All such events are monitored and evaluated and appropriate action taken depending on the nature of the adverse reaction
9. Such action may take the form of observation or in extreme cases withdrawal of the drug throughout the hospital.
10. Drug causing adverse reaction is closely monitored and analyzed by drug and therapeutic committee

1. Drug Recall Procedure

1. Once the drug causing adverse reaction is identified, particular batch of the drug is immediately withdrawn by pharmacy, wherever issued within the hospital.
2. Company & distributor are immediately informed regarding the adverse reaction and called to find out the reasons & actions to be taken.
3. Total medicine of that particular batch is returned to supplier.
4. Report is presented before Quality management committee and further action is taken.

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SUSPECTED ADVERSE DRUG REACTION REPORTING FORM

For VOLUNTARY reporting
of Adverse Drug Reactions
by health care professionals

Report #

To be filled in by Pharmacovigilance
centres receiving the form.

A. Patient information			
1. Patient identifier initials	2. Age at time of event: or Date of Birth:	3. Sex: <input type="checkbox"/> M <input type="checkbox"/> F	4. Weight _____ Kgs
In confidence			
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 <input type="checkbox"/> Death (dd/mm/yy) <input type="checkbox"/> Congenital anomaly <input type="checkbox"/> Life threatening <input type="checkbox"/> Required intervention to prevent permanent impairment/ damage <input type="checkbox"/> Hospitalization-initial or prolonged <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Disability
15. Outcomes <input type="checkbox"/> Fatal <input type="checkbox"/> Recovering <input type="checkbox"/> Unknown <input type="checkbox"/> Continuing <input type="checkbox"/> Recovered <input type="checkbox"/> Other (specify) _____

C. Suspected medication(s)										
Sl. No.	B. Name (brand and / or generic name)	Manufacturer (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 _____				

SAND