



ADVERSE MEDICINE REACTION REPORTING FORM (For Healthcare Professionals)



A) PATIENT INFORMATION				Safety Yellow Form Confidential		
Patient Initials or Hospital Reg. No.		DOB...../...../..... or Age.....	Gender <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unk.		Weight (Kg):	
Pregnant <input type="checkbox"/> Y <input type="checkbox"/> N	If YES, Estimated Gestational Period:	Known Allergies:				
B) TYPE OF REPORT Initial <input type="checkbox"/> Follow up <input type="checkbox"/> If Follow up, AMR ID No. :						
DESCRIPTION OF ADVERSE EVENTS Indicate provisional/ final diagnosis of the adverse events		Date event started	Date event stopped	Action Taken: (e.g. Medicine withdrawn/substituted/dose reduced/medical treatment etc...)		
SERIOUSNESS		<input type="checkbox"/> Hospitalization <input type="checkbox"/> Disability or permanent damage <input type="checkbox"/> Congenital anomaly/birth defect <input type="checkbox"/> Life-Threatening <input type="checkbox"/> Non Serious adverse event <input type="checkbox"/> Other; Specify:				
PATIENT OUTCOME		<input type="checkbox"/> Recovered <input type="checkbox"/> Recovered with sequelae <input type="checkbox"/> Due to Reaction <input type="checkbox"/> Reaction maybe contributory <input type="checkbox"/> Recovering <input type="checkbox"/> Not recovered <input type="checkbox"/> Unknown Died <input type="checkbox"/> Unrelated to reaction Date of death:/...../.....				
C) RELEVANT LABORATORY TEST (May be attached if necessary)						
Were there any relevant laboratory test(s) done? <input type="checkbox"/> Y <input type="checkbox"/> N						
Laboratory Test		Test Date	Test Results			
D) RELEVANT MEDICAL HISTORY: including pre-existing medical conditions (e.g. diabetes, liver problem, alcohol use etc.)						
E) INFORMATION ON MEDICINE: For vaccines please complete the AEFI reporting form						
Trade Name [Generic Name if Trade Name is unknown] -List medicines used in the last 3 months -Enter Fixed Dose Combination as one medicine -Tick suspected medicine (s)		Dose and Frequency	Route of admin	Start date	Stop date or ongoing	Reason for use
F) REPORTER INFORMATION						
Name		Email		Tel:		
Profession		<input type="checkbox"/> Doctor <input type="checkbox"/> Pharmacist <input type="checkbox"/> Nurse <input type="checkbox"/> Pharm Ass		<input type="checkbox"/> Others:		
Health Facility/ Practice Name			Region	Date:		
Please note that submission of a report does not constitute an admission that medical personnel or the medicine caused or contributed to the event						
Please tick IF YOU need: <input type="checkbox"/> More AMR forms <input type="checkbox"/> Additional information						

Send/Fax/Fax2Mail/Email to:
 Therapeutics Information and Pharmacovigilance Centre (TIPC)
 15 Ruhr Street Northern Industry, Windhoek
 Tel: (061) 203 2406/ 203 2312
 Fax: (061) 226631
 Fax2Mail: 0886606781
 Email: info.TIPC@mhss.gov.na