Ministry of Health and Social Services

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** ☐M ☐ F ☐ Unk.	**Weight (Kg):**	
Pregnant ☐ **Y** ☐ **N**	**If YES, Estimated Gestational Period:**	**Known Allergies:**		
B) TYPE OF REPORT	**Initial** ☐ **Follow up** ☐ **If Follow up, AMR ID No. :**			

DESCRIPTION OF ADVERSE EVENTS Indicate provisional/ final diagnosis of the adverse events	Date adverse event started	Date adverse event stopped	Action Taken: (e.g. Medicine withdrawn/substituted/dose reduced/medical treatment etc…)

SERIOUSNESS	☐ **Hospitalization** ☐ **Disability or permanent damage** ☐ **Congenital anomaly/birth defect** ☐ **Life-Threatening** ☐ **Non Serious adverse event** ☐ **Other; Specify: ……**	
PATIENT OUTCOME	☐ **Recovered** ☐ **Recovered with sequelae** ☐ **Recovering** ☐ **Not recovered** ☐**Unknown**	**Died** ☐ **Due to Reaction** ☐ **Reaction maybe contributory** ☐ **Unrelated to reaction** **Date of death: ……/……/……**

C) RELEVANT LABORATORY TEST (May be attached if necessary)

Were there any relevant laboratory test(s) done? ☐ **Y** ☐ **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***

Suspect Medicine(s) [Medicines suspected to have caused the AMR]

Trade Name [Generic Name if Trade Name is unknown]	**Route**	**Dose (mg) and Interval**	**Date Started/Given**	**Date Stopped**	**Reason for use**	**Batch Number**	**Expiry Date**

All other Medicines Patient was taking at time of reaction [Including over-the-counter and herbal products]

Trade Name [Generic Name if Trade Name is unknown	**Route**	**Dose (mg) and Interval**	**Date Started/Given**	**Date Stopped**	**Reason for use**	**Batch Number**	**Expiry Date**

F) REPORTER INFORMATION

Name		**Email**		**Tel:**	
Profession	☐ **Doctor** ☐ **Pharmacist** ☐ **Nurse** ☐ **Pharm Ass** ☐ **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

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ADVICE ABOUT VOLUNTARY REPORTING

Report adverse experiences with:
- medications (drugs, vaccines and biologicals)
- medical devices (including in-vitro diagnostics)
- complementary / alternative medicines (including traditional, herbal remedies, etc.)

Report even if:
- you're not certain the product caused the event
- you don't have all the details

Please report especially:
- adverse drug reactions to newly marketed products
- serious reactions and interactions with all products
- adverse drug reactions which are not clearly reflected in the package insert.

All reports should be forwarded to:

Namibia Medicines Regulatory Council (NMRC),
Therapeutics Information and
Pharmacovigilance Centre (TIPC),
44, Bismarck Street Windhoek
Tel: (061) 203 2406/ 203 2312
Call/WhatsApp: (081) 1 465406
Email: info.TIPC@mhss.gov.na

Your support of the Namibian Medicines Regulatory Councils's adverse drug reaction monitoring programme is much appreciated. Information supplied by you will contribute to the improvement of medicine safety and therapy in Namibia.