Adverse Drug Reaction Form

Patient Details	
Age*:	Gender*: □ Female □ Male
Suspected Product Details	
Trade Name*: Generic Name*: Indication*:	Batch No.*: Expiry date:
Origin of Dispensing: □ Community pharmacy without Prescription □ Community pharmacy with Prescription □ Hospital pharmacy □other/specify: ————————	
Description of the adverse Drug Reaction (ADR)	

Event Onset Date: / /	Event End Date: / /
Action Taken: what happened after adverse reaction? □Drug discontinued □Dose reduced □Dose increased □Unknown	
Was there a relevant Medical History?	

Reporter Details	
Reporter name*:	Mobile number*:
Profession (Specialty):	E-mail*:
Address:	Date of Report:
Please: send reporting form and attached any supportive documentation and/or report to:	
IBSA SCIENTIFIC OFFICE (KSA). Tahlyia street, Moton towers (South tower), 1st floor, office #: 103, Olaya District, Riyadh Tel: +966 11 4629682 ext. 105 Mobile: +966 554456187 e-mail: **pv@ibsascientificoffice.sa**. Or through Pharmacovigilance page on the website: www.ibsascientificoffice.sa	

* This field is required

Related to the Pharmacovigilance Department

Date of receipt ADR report: / /
Received By: ---------- Country: ----------
Source type: □ Spontaneous □ Literature study □ Initial report □ Follow-up report