

## PHILLIPS PHARMA GROUP – REPORT AN ADVERSE REACTION\*

\* any untoward medical occurrence that may present during treatment with a medicine, but which does not necessarily have a causal relationship with this treatment – coincidence in time without any suspicion of causal relationship, or a response to a medicine which is noxious (harmful) and unintended, and which occurs at doses normally used in humans, including:

- Abnormal tests or laboratory findings
- Signs and symptoms of clinical significance
- Changes in physical examination findings
- Hypersensitivity
- Progression of underlying disease
- Drug interaction
- Drug dependency

Please fill out the form below and send to the email address indicated in the footer:

<b>Patient Initials</b>		First Initial:	Last Initial:
<b>Country</b>			
<b>Date of Birth</b>		DD-MMM-YYYY	
<b>Gender</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female		
<b>Date of reaction onset</b>		DD-MMM-YYYY	
<b>Describe Reaction</b>			
<b>Please check all results applicable to adverse reaction</b>		<input type="checkbox"/> Patient died <input type="checkbox"/> Involved or prolonged inpatient hospitalization <input type="checkbox"/> Involved persistence or significant disability or incapability <input type="checkbox"/> Life threatening	
<b>Suspect drug(s) including generic name</b>			
<b>Batch number of suspect drug</b>			
<b>Source of medicine</b>			
<b>Daily dose(s)</b>			
<b>Route(s) of administration</b>		<input type="checkbox"/> Oral <input type="checkbox"/> Intravenous (IV) <input type="checkbox"/> Intramuscular (IM) <input type="checkbox"/> Intrathecal <input type="checkbox"/> Subcutaneous <input type="checkbox"/> Buccal <input type="checkbox"/> Rectal <input type="checkbox"/> Vaginal <input type="checkbox"/> Ocular	<input type="checkbox"/> Otic <input type="checkbox"/> Transnasal <input type="checkbox"/> Inhalation <input type="checkbox"/> Nebulization <input type="checkbox"/> Topical <input type="checkbox"/> Transdermal <input type="checkbox"/> Intraosseous <input type="checkbox"/> Other:
<b>Indication(s) for use</b>			
<b>Therapy dates</b>		FROM:	TO:
<b>Therapy duration</b>			
<b>Did reaction abate after stopping drug?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	

Please send completed form to: [pv.submissions@phillipsnigeria.com](mailto:pv.submissions@phillipsnigeria.com)

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<b>Did reaction reappear after reintroduction?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	
<b>Concomitant drug(s) and dates of administration (exclude those used to treat reaction)</b>		
<b>Other relevant history (eg: diagnostics, allergies, pregnancy with last month of period, etc.)</b>		
<b>Name and address of manufacturer</b>		
<b>Report source</b>	<input type="checkbox"/> Patient <input type="checkbox"/> Study <input type="checkbox"/> Literature <input type="checkbox"/> Health Professional <input type="checkbox"/> Other	
<b>Date of report</b>		
<b>Report type</b>	<input type="checkbox"/> Initial <input type="checkbox"/> Follow Up	
<b>Your email</b>		We may need to get in touch with you for follow up or details
<b>Your phone number</b>		
<b>Upload any relevant attachments</b>		Prescription, results, images, etc.
<b>Consent</b>	<input type="checkbox"/> We may share your data with third parties but keep your information confidential.	

Please note that any data provided herein, in any form, is collected and will be processed by us in accordance with the prevailing laws and regulations in the land. By submitting your information, you expressly consent to the collection and processing of your data.

Please send completed form to: [pv.submissions@phillipsnigeria.com](mailto:pv.submissions@phillipsnigeria.com)

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