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:

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

Please send completed form to: pv.submissions@wessexrwanda.com

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Did reaction reappear after reintroduction?	☐ Yes ☐ No ☐ Not Applicable	
Concomitant drug(s) and dates of administration (exclude those used to treat reaction)		
Other relevant history (eg: diagnostics, allergies, pregnancy with last month of period, etc.		
Name and address of manufacturer		
Report source	☐ Patient ☐ Study ☐ Literature ☐ Health Professional ☐ Other	
Date of report		
Report type	☐ Initial ☐ Follow Up	
Your email		We may need to get in touch with you for follow up or details
Your phone number		
Upload any relevant attachments		Prescription, results, images, etc.
Consent	☐ 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@wessexrwanda.com