CONSUMER REPORTING FORM FOR ADVERSE DRUG REACTIONS

##### **Describe what happened**

Describe what happened in your own words, any symptoms or side-effects you suspect were caused by your medicine, and what happened since then. Other specific details about each medicine and relevant dates can be entered below, but please include enough information here to connect to the “Reactions/Symptoms” section below

**Description**

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**Reactions/Symptoms**

Describe the reactions in your own words. Record each reaction/symptom separately

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Reaction/ Symptom** | **Start date (when the reactions started)** | **End date (when the reaction ended)** | **Duration of reaction/symptom** | **Outcome of reaction (recovered, recovering, not recovered, recovered with lasting effects, died, unknown)** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Did the reaction lead to any of the following? Tick the applicable option

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Death** | **Life threatening** | **Disabling/incapacitating** | **Caused/prolonged hospitalisation** | **Congenital anomaly/birth defect** | **Other medically important condition** |

**Medicines(s)**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Medicine name** | **Medicine manufacturer (Company name written on package)** | **Batch number** | **Strength (e.g. 50mg, 10mg/ml)** | **Dosage (how much did you take, e.g. 2 tablets 3 times a day)** | **How was the medicine administered (e.g., orally, injection into a vein)** | **Start date (when did you start taking the medicine)** | **End date (when did you stop taking the medicines)** | **Reason for taking the medicine (e.g. diabetes, headache)** | **Action taken with the medicine (e.g. stopped taking medicine, dose reduced, dose increased, dose not changed, unknown, not applicable)** |
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|  |  |  |  |  |  |  |  |  |  |

**Current and previous illnesses**

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**Additional comments**

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**User of the medicines**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Initials | Sex/Gender | Weight | Height | Date of birth/Age |
|  |  |  |  |  |

**Contact details**

|  |  |
| --- | --- |
| Email | Telephone number |
|  |  |

\*Please attach any other additional information such as an anonymized picture of the adverse reaction or a picture of the package containing the medicine or the medicine itself.

**NB:** This form may be completed for any ADR related to medicines or medical devices. You may also submit a report online using the MCAZ e-PV system, accessible from the URL <https://e-pv.mcaz.co.zw>, or from the mobile apps, which can be downloaded from the Google Play Store and the Apple App Store by searching for and downloading the app “MCAZ Pharmacovigilance”. The user manuals for using the MCAZ e-PV system can be downloaded from the MCAZ website, [www.mcaz.co.zw](http://www.mcaz.co.zw)