JBCPL SUSPECTED ADVERSE DRUG REACTION REPORTING FORM

JB Chemical & Pharmaceuticals Ltd.

Corporate Address: Cnergy IT Park, Unit A2, 3rd Floor, Appa Saheb Marathe Marg, Prabhadevi, Mumbai – 400 025.

Report Type □ Initial □ Follow up

A. PATIENT INFORMATION

1. Patient Initials _____	2. Age at time of Event or Date of Birth_____	3. M □ F □ Other □ 4. Weight_____ Kgs.

12. Relevant tests/laboratory data with dates

B. SUSPECTED ADVERSE REACTION

5. Date of reaction started (dd/mm/yyyy)

6. Date of recovery (dd/mm/yyyy)

7. Describe reaction of problem

13. Relevant medical/medication history (e.g. allergies, race, pregnancy, smoking, alcohol use, hepatic/renal dysfunction etc.)

14. Seriousness of the reaction: No □ if Yes □ (please tick anyone)

□ Death (dd/mm/yyyy) □ Congenital-anomaly

□ Life threatening □ Required intervention to Prevent permanent impairment / damage

□ Hospitalization/Prolonged

□ Disability □ Other (Specify)

15. Outcomes

□ Recovered □ Recovering

□ Not recovered □ Fatal

□ Recovered with sequelae □ Unknown

C. SUSPECTED MEDICATION(S)

S.No	8. Name (Brand/Generic)	Manufacturer (if known)	Batch No./Lot No.	Exp. Date (if known)	Dose used	Route used	Frequency (OD, BD etc.)	Therapy dates		Indication	Causality Assessment
								Date started	Date stopped		
i											
ii											
iii											
iv											

S No. as per C	9. Action Taken (Please tick)						10. Reaction reappeared after reintroduction (please tick)			
	Drug withdrawn	Dose increased	Dose reduced	Dose not changed	Not applicable	Unknown	Yes	No	Effect unknown	Dose (if reintroduced)
i										
ii										
iii										
iv										

11. concomitant medical product including self-medication and herbal remedies with therapy dated (Exclude those used to treat reaction)

S.No	Name (Brand/Generic)	Dose used	Route used	Frequency (OD, BD, etc)	Therapy dates		Indication
					Date started	Date stopped	
i							
ii							
iii							

Additional Information:

D. REPORTER DETAILS

16. Name and Professional Address:_____

_____

Pin:_____ E-mail_____

Tel.No. (with STD code)_____

Occupation:_____

Signature:_____

17. Date of this report (dd/mm/yyyy):

Confidentiality: The patient's identity is held in strict confidence and protected to the fullest extent.