TEOFARMA S.r.l.

SUSPECT ADR

CONTACT INFORMATION: ☐ TELEPHONE ☐ MAIL ☐ FAX

CONTACT QUALIFICATION:

☐ PATIENT

☐ PHARMACIST

☐ PHYSICIAN

☐ OTHER _____

CONTACT DETAILS:

NAME: _____

ADDRESS: _____

TEL: _____

E-MAIL: _____

MEDICAL HISTORY:

SUMMARY_____
_____
_____
_____
_____

PATIENT:

NAME (INITIALS): _____

COUNTRY: _____

AGE: _____

SEX: ☐ FEMALE ☐ MALE

TEOFARMA S.r.l.

TEOFARMA'S PRODUCT : _____

☐ THERAPEUTIC INDICATIONS_____

☐ ADMINISTRATION PERIOD FROM: TO:

☐ DOSAGE ☐ ADMINISTRATION ROUTH

☐ OTHER DRUGS ADMINISTRATED DURING THE EVENT ☐ NO ☐ YES

_____

☐ ADVERSE REACTION_____

☐ PERIOD OF ADVERSE REACTION FROM: TO:

☐ OUTCOME: ☐ RESOLVED ☐ IMPROVING

☐ NOT RESOLVED

☐ RESOLVED WITH SEQUELEA

☐ FATAL ☐ UNKNOWN

☐ OTHER _____

COMMENTS/NARRATIVE

_____
_____
_____
_____
_____
_____
_____
_____
_____

I agree that Teofarma contacts my treating physician to obtain additional information or clarification on this adverse event.

☐ NO ☐ YES (please give address)

REPORTER NAME: _____

SIGN: _____ DATE: _____