WOCKHARDT LiFE WiNS

TITLE	WOCKHARDT ADR COLLECTION FORM (SUSPECTEDADVERSEDRUGREACTIONREPORTINGFORM FORVOLUNTARYREPORTINGOF ADVERSEDRUGREACTIONSBYHEALTHCAREPROFESSIONAL)

Wockhardt Corporate Office, Wockhardt Limited,
Wockhardt Towers, Bandra Kurla Complex,
Bandra (East), Mumbai-400051, India.
Phone: 022-2659 6776 Fax: 022-26523905
Toll-free ADR Reporting Number: 1800-258-8127
Email: pvsafety@wockhardt.com

Wockhardt Reference No:

(To be filled by Wockhardt PV department)

A. Patient Information

1. Patient Initials	2. Age at time of Event or date of birth	3. Sex M ☐ F ☐
		4. Weight Kgs

B. Suspected adverse reaction :

5. Date of reaction stated (dd-mmm-yyyy):

6. Date of recovery (dd-mmm-yyyy):

Describe reaction or problem:

12.Relevant tests / laboratory data with dates

13. Other relevant history including pre-existing medical conditions (e.g. allergies, race, pregnancy, smoking, alcohol use, hepatic/ renal dysfunction etc)

14. Whether the reaction is Serious - Yes / No (Please Tick)

Death (dd-mmm-yyyy) ☐	Congenital anomaly ☐
Life threatening ☐	Required intervention to prevent permanent impairment / damage ☐
Hospitalization-initial or prolonged ☐	
Disability ☐	Other (specify) ☐

15.Outcomes (Please tick relevant box)

☐ Fatal	☐ Recovering	☐ Unknown
☐ Continuing	☐ Recovered	☐ Other (Specify)______

C. Suspected medication(s):

S.No	8. Name (brand and /or generic name)	Manufacturer (if known)	Batch No/ Lot No. (if known)	Expiry. Date (if known)	Dose used	Route used	Frequency	Therapy dates (if known give duration)		Indication (S)
								Date Started	Date Stopped	
i.										
ii.										

Sl. No As per C	9. Reaction abated after drug stopped or dose reduced					10. Reaction reappeared after reintroduction				
	Yes	No	Unknown	NA	Reduced dose	Yes	No	Unknown	NA	If reintroduced dose
i.										
ii.										
iii.										

11. Concomitant medical product including self-medication and herbal remedies with therapy dates (exclude those used to treat reaction)

17. Causality Assessment	18. Date of this report (dd-mmm-yyyy)

D. Reporter details:

16. Name and Professional Address :

Pin code:____________
Tel. No. (with STD code):
E-mail:

Occupation: **Signature:**