TITLE	WOCKHARDT ADR COLLECTION FORM (SUSPECTED ADVERSE DRUG REACTION REPORTING FORM FOR VOLUNTARY REPORTING OF ADVERSE DRUG REACTIONS BY HEALTHCARE PROFESSIONAL)

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Wockhardt Towers, Bandra Kurla Complex,
Bandra (East), Mumbai-400051, India.
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11. Wockhardt Reference No:
(To be filled by Wockhardt only)

A. Patient Information

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

B. Suspected adverse reaction

12. Relevant tests / laboratory data with dates

5. Date of reaction started:

6. Date of recovery:

7. Describe reaction or problem:

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/mm/yyyy) ☐	Congenitial 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):

Sl. 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	

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

Concomitant Medication(s):		**D. 16 Reporter details**	
		Name	
		Address	
		Tel. No.	
		E-mail id	
		Occupation	
		Signature	
17. Causality Assessment	**18. Date of this report (dd/mm/yyyy)**	**Consent to follow up**	