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

Wockhardt Corporate Office, Wockhardt Limited,
Wockhardt Towers, Bandra Kurla Complex,
Bandra (East), Mumbai-400051, India.
PV Safety Toll-free No. 18002588127, 022-71596770
Email: pvsafety@wockhardt.com

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

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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	