**NOTIFICATION OF SIDE EFFECT OF A MEDICINAL PRODUCT BY PROFESSIONAL HEALTHCARE WORKERS**

* *CONFIDENTIAL –*

**INFORMATION ABOUT THE PATIENT**:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Initials | Date of birth | | | Age | Sex:  □ F  □ M | Weight | Height |
| Day | Month | Year |  |  |  |  |

**INFORMATION ABOUT SIDE EFFECT**:

|  |  |
| --- | --- |
| Date of side effects: | Classification  Has the side effect been serious  □ Yes  □ No  Mark appropriate reaction:  □ death  □ life threatening  □ permanent or significant disability or impairment of performance  □ hospitalization or prolonged stay in hospital  □ other, which a doctor at his/her discretion considers as serious  Statistical number of the reason of death ……………………………………………. |
| Description of side effects: |
| Result:  □ Recovery without permanent effects  □ Recovery with permanent effects  □ during the treatment of symptoms  □ Unknown |
| Pregnancy:  □ No  □ Yes; if yes, please indicate the week of pregnancy ………………………. |

**INFORMATION ABOUT MEDICINES:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Name of medicine | Mark “P” if you suspect the medicine to cause symptoms | Dosage (*eg. 20 mg twice a day)* | Route of administration (*eg. oral*) | Date the administration of the medicine started | Date the administration of the medicine finished | Reason for taking or statistical number of the disease | |
|  |  |  |  |  |  |  | |
| **ADDITIONAL INFORMATION**: eg. previous reactions to the medicine, risk factors, results of additional tests | | | | | | |

**DATA OF THE NOTIFYING PERSON:**

Name and surname ……………………………………………………………Specialization ……………………………

Address ………………………………………………………………………………………………………………………………….

Telephone …………………………………………………….. Fax: ……………………………………………………………….

E-mail: ……………………………………………………………………Date and signature ………………………………..