ADVERSE EVENT REPORTING FORM

Patient Details						
Patient Initials/identifier						
Age at the time of event			or	Date of Birth	DD/MM/YYYY	
Weight		Kg/Lb		Height	cm/ft	
Gender	□ Male	□ Female	□ Other (Specify)	Pregnant	□ Yes	□ No
Other relevant history including pre-existing medical conditions:						

Our product details				
S.No	Suspect Drug Name (formulation/strength/route)	Start date	End date	Frequency
1.				
2.				
3.				

S.No	Indication	Drug discontinued?	Lot /Batch number	Expiry date
1.				
2.				
3.				

Concomitant medications (Any other medications consumed along with our company drugs):

Adverse Event details
AE term(s):

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Description of adverse events: (including sign and symptoms with specific diagnosis, treatment and action taken):					
Outcome:					
□ Fatal	□ Ongoing	□ Recovering	□ Recovered	□ Recovered with sequela	□ Unknown
Date of event onset	DD/MM/YYYY		Date of Resolution	DD/MM/YYYY	
Lab test Details (with dates, results and normal range) :					

Reporter Details			
Full Name			
Address			
Email		Phone	
Occupation			
Consent to contact Healthcare Professional (HCP) / Prescribing Physician		□ Yes	□ No
If yes, provide contact Healthcare Professional (HCP) / Prescribing Physician details			
Full Name			
Address			
Qualification			
Email		Phone	

Please send the completed form to:

Global Pharmacovigilance Department,
PTC, Cadila Healthcare Limited,
Sarkhej-Bavla N.H.No 8A, Moraiya, Tal: Sanand,
Ahmedabad – 382210, Gujarat, India.

Or email the scanned copy to drugsafety@zyduscadila.com