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Report № _____/_____
❑ initial ❑ final
(filled by Pharmacovigilance service)

REPORT ON MISUSE OF MEDICINAL PRODUCT

ALL THE INFORMATION GIVEN BY YOU IS CONFIDENTIAL AND NON-DISCLOSABLE EXCEPT AS OTHERWISE PERMITTED BY LAW

INFORMATION ABOUT PATIENT

Full name:		**Hepatic diseases**	❑ yes ❑ no ❑ no information
№ of medical treatment record / case history:		**Renal diseases**	❑ yes ❑ no ❑ no information
Sex:	❑ male ❑ female	**Pregnancy**	❑ yes **Duration** _____ weeks
Age (at the moment of reaction):		**Allergy** (please specify):	❑ yes ❑ no
Weight (kg):			

MISUSED MEDICINAL PRODUCT (-S) (MP)

Trademark	International Nonproprietary Name	Pharmaceutical form	Batch	Dosage, frequency and route of administration	Indications for use	Start date of administration	End date of administration

OTHER MEDICINAL PRODUCTS (administered in the last 3 months)

Trademark	International Nonproprietary Name	Pharmaceutical form	Batch	Dosage, frequency and route of administration	Indications for use	Start date of administration	End date of administration

EFFECTS OF MISUSE OF MP (MU MP)

Description of effects of MU MP (including results of laboratory and instrumental tests)	Start date	End date

Did MP withdrawal result in disappearance of MU MP effects? ❑ yes ❑ no

Measures taken:
❑ MP withdrawal
❑ pharmacological therapy of MU MP effects (please specify):

❑ non-pharmacological therapy of MU MP effects (including surgical treatment)
❑ other (please specify):

Result:
❑ full recovery without consequences
❑ amelioration
❑ no changes
❑ death caused by MU MP
❑ death not caused by MU MP
❑ recovery with any consequences (please specify):
❑ no information

Severity criteria:
❑ death of the patient (date ___/___/_____)
❑ danger to life
❑ hospitalization or its prolongation
❑ prolongation of out-patient treatment
❑ disability
❑ congenital abnormality
❑ clinically significant event (please specify):

INFORMATION ABOUT REPORTER (person that informs about MU MP)

Full name:			
Occupation:	❑ doctor ❑ pharmacist ❑ medical representative ❑ patient ❑ other (please specify):		
Address:			
Phone:		**E-mail:**	
Date of MU MP information receiving:		**Filling date:**	

SIGNATURE_____