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

REPORT ON INTERACTION OF MEDICINAL PRODUCT WITH OTHER DRUGS OR FOOD ITEMS

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:		**Allergy** (please specify):	❑ yes ❑ no
Weight (kg):			

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

FOOD ITEM (-S)

Name	Preparation method	Quantity	Date of use

EFFECTS OF MP INTERACTION (IA MP)

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

Did MP withdrawal result in IA MP effects disappearance? ❑ yes ❑ no

Measures taken:
❑ no measures
❑ MP withdrawal
❑ pharmacological therapy of IA MP effects (please specify):

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

Result:
❑ full recovery without consequences
❑ amelioration
❑ no changes
❑ death caused by IA MP
❑ death not caused by IA 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 IA MP)

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

SIGNATURE _____