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

REPORT ON IMPROPER ADMINISTRATION MODE 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):			

IMPROPER ADMINISTERED 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 IMPROPER ADMINISTRATION MODE OF MP (IAM MP)

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

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

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

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

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

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

SIGNATURE ________________________________