KUSUM PHARM, LLC
Address: p/o box 22, Kyiv-02092, Ukraine
Tel: (044)4958287; (067)4340378 Fax: (044)4958287
Email: vigilance@gladpharm.com

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

REPORT ON MEDICINAL PRODUCT ADMINISTRATION DURING PREGNANCY / BREASTFEEDING

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):		**Breastfeeding**	❑ yes **Age of baby** _____
Weight (kg):		**Allergy** (please specify):	❑ yes ❑ no

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 MP ADMINISTRATION DURING PREGNANCY / BREASTFEEDING (P/BF MP)

Description of P/BF MP effects (including results of laboratory and instrumental tests)	Start date	End date

Measures taken:
❑ no measures
❑ some measures (please specify):
❑ MP withdrawal
❑ MP dose adjustment

Result:
❑ no information
❑ changes in pregnancy course (please specify):
❑ changes in baby health (please specify):

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

INFORMATION ABOUT REPORTER (person that informs about P/BF MP event)

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

SIGNATURE _____