Foreign Enterprise «*Baraka Dori Farm*» LLC, *91 Kichik halqa yo'li, Yakkasaray district, Tashkent, Uzbekistan*
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Email: *pv@kusum.uz* *https://kusum-healthcare.uz*

Report №_____/_____
☐ initial ☐ follow up ☐ final

(Should be filled by Pharmacovigilance Department)

ADVERSE DRUG REACTION REPORT

ALL PROVIDED INFORMATION IS CONFIDENTIAL AND NON-DISCLOSURE WITH THE EXCEPTION OF THE CASES STIPULATED BY LAW

INFORMATION ABOUT REPORTER (person, who reports about ADR)

Name:	**Professional belonging:**
Place of employment:	**Address:**
Telephone/Mobile:	**E-mail:**

INFORMATION ABOUT PATIENT (CONSUMER)

Initials:	**Sex:** ❑ male | ❑ fem | ❑ unknown	**Weight** (кг):	**Age**: ❑ unknown
Liver disease: ❑ Yes | ❑ No | ❑ unknown		**Kidney disease:** ❑ Yes | ❑ No | ❑ unknown	
Allergy: ❑ Yes (specify the allergen) | ❑ No | ❑ unknown		**Pregnancy:** ❑ Yes **Term** _____ weeks| ❑ No | ❑ unknown	
		Additional information:	

SUSPECTED MEDICINAL PRODUCT (-S)

Product (trade name, dose, pharmaceutical form)	**Batch**	**Frequency and method of administration**	**Indication**	**Date of start**	**Date of stop**

OTHER MEDICINES

Medicine (trade name, pharmaceutical form, dose, active substance)	**Batch**	**Frequency and method of administration**	**Indication**	**Date of start**	**Date of stop**

INFORMATION ABOUT ADVERSE DRUG REACTION

Detailed description of ADR	❑ ADR are continuing	**Start date:** (____/____/_____)	**Date of stop:** (____/____/_____)

Did the ADR disappear after the drug was stopped? ❑ Yes \| ❑ No \| ❑ Drug was not stopped

Did the ADR reappear after the drug was reintroduced? ❑ Yes \| ❑ No \| ❑ Drug was not reintroduced

Actions taken to treat the ADR: ❑ Drug withdrawal \| ❑ Dose reducing \| ❑ Co-treatment cessation \| ❑ None \| ❑ Medicinal therapy \| ❑ Non-medicinal therapy ❑ Other (indicate):

Treatment of ADR:

Outcome: ❑ Recovering without consequences \| ❑ Improvement of state \| ❑ State without changes \| ❑ Death \| ❑ Unknown ❑ Recovering with the consequences (indicate):

Criterion of seriousness: ❑ Death (date ___/___/_____) \| ❑ Life threatening \| ❑ Hospitalization – initial or prolonged \| ❑ Disability ❑ Congenital malformations \| ❑ Important medical event (indicate): ❑ None

Employee name: _____ **Position:** _____ **Region:** _____

Information receive date: _____ **Date sent in company**: _____ **Signature:** _____