Baraka dori farm

Foreign Enterprise ***«Baraka Dori Farm» LLC, 91 Kichik halqa yo'li, Tashkent, Uzbekistan***
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Report №____/________
☐ **initial** ☐ **follow up** ☐ **final**

(Should be filled by Pharmacovigilance Department)

REPORT OF LACK OF EFFICACY OF PHARMACEUTICAL PRODUCT

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 LACK OF EFFICACY (LOE)

Detailed description of LOE	**Start date:** (_____/_____/_________)	**Date of stop:** (____/____/________)

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

Did the LOE 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 LOE:

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:** __________________