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Report №/_ □ initial □ follow up □ final	
(Should be filled by Pharmacovigilance Department)	

## **QUALITY COMPLAINT REPORT**

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

INFORMATION ABOUT REPORTER (per	son, who reports	about QC)				
Name:		Professional belonging:				
Place of employment:		Address:				
Telephone/Mobile:		E-mail:				
INFORMATION ABOUT PATIENT (CON	(SUMER)					
Initials: Sex: ☐ male ☐ fem		Weight (кг):	Age:	unknown		
Liver disease:		Kidney disease:				
<b>Allergy:</b> ☐ Yes (specify the allergen)   ☐ No	□ unknown	Pregnancy: ☐ Yes Term weeks  ☐ No   ☐ unknown				
		Additional info	ormation:			
INFORMATION ABOUT MEDICINAL PI	RODUCT					
Medicinal product (trade name, dose, pharmaceutical form)	Batch	Expiration date	Indication	Purchase place (pharmacy, address)	Purchase date	
QUALITY COMPLAINT INFORMATION	N					
	Con	mplaint description	1			
Employee name:	Positio	on:	Region:			
Information receive date: Date sent in company:			Signature:			