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| **PHARMACOVIGILANCE CENTRE****DEPT. OF PHARMACOLOGY, IGMC & RI, PUDUCHERRY-605009**Ph: 0413-2277545 Extn : 3056 Email: pharmacologyigmcri@gmail.com |
| **NOTIFICATION FORM FOR SUSPECTED ADVERSE DRUG REACTION**  |
| Patient name………………………………….................................................. Age……………. Sex…….I.P/O.P No ………………………………………………………………Unit/Dept……………………………………………………………. |
| Suspected drug(s)…………………………………………………………………………………………………………………………………Concomitant Drugs………………………………………………………………………………………………………………………………..Diagnosis……………………………………………………………………………………………………………………………………………….Outcome: Fatal  Recovering  Recovered  Continuing  Others………………………………Brief description of reaction…………………………………………………………………………………………………………………..……………………………………………………………………………………………………………………………………………………..………………………………………………………………………………………………………………………………………………………………………….. |
| Reporter’s Name & Phone No………………………………………………………………………………………………………………….Signature……………………………………………………………….…………..Date…………………………………………………………….. |
| **Please return this form to Dept. of Pharmacology, IGMC &RI as soon as possible.** |