1. Reporter Details		☐Initial ☐Follow-up
Reporter Name:		E-mail:
Contact address:		Telephone number:
		Fax number:
Type:	☐ Physician (Specialty): _____	☐ Consumer or other non healthcare professional
	☐ Pharmacist	☐ Other (Specify) _____

If reporter is a consumer, have they informed their physician of the exposure?	☐ Yes	☐ No
Has the consumer provided permission to contact their healthcare professional?	☐ Yes	☐ No

If yes, please provide healthcare professional contact details:		
Name:	Type:	Telephone:
Address:		Email:

2. Patient Details			
Date of birth (Day/Month/Year)	Age Yrs/mo.	Height cm	Weight kg

3. Company Drug Section									
	Name	Strength	Dose	Route	Indication	Treatment start date (day/month/year)	Treatment end date (day/month/year)	Lot	Expiry
1.									
2.									
3.									

4. Details of Adverse Event					
Adverse Event	Start Date (day/month/year)	Stop Date (day/month/year)	Hospitalization	Outcome	Event Causality
			☐ Yes ☐ No *If yes, provide dates of hospitalization.*	☐ Recovered / Resolved ☐ Recovered / Resolved With Sequelae ☐ Recovering /Resolving ☐ Not Recovered /Not Resolved ☐ Fatal ☐ Unknown	☐ Related ☐ Not Related ☐ Unknown

5. Liver Function Tests			
	Date (day/month/year)	**Results**	**Normal Range**
Alanine transaminase (ALT)			
Aspartate transaminase (AST)			
Alkaline phosphatase (ALP)			
Albumin			
Total protein (TP)			

Bilirubin			
Gamma-glutamyltransferase (GGT)			
L-lactate dehydrogenase (LD)			
Prothrombin time (PT)			

6. Treatment

Treatment provided for event:
Action taken with Company Drug in response to event:

7. Concomitant Drugs & Therapies

8. Medical History

Patient's concomitant conditions, relevant medical history, known risk factors, relevant tests, laboratory data.

☐ Viral illness	☐ Hepatitis
☐ Hepatitis virus infection	☐ Cholelithiasis
☐ Autoimmune disease	☐ Prone to bleeding or bruising
☐ Blood transfusion	☐ Intravenous drug use
☐ Drug abuse	☐ Recent tattoos
☐ Recent travel	☐ Toxic exposure
☐ Anesthesia use/Surgery	☐ Steroid use
☐ Use of herbal supplements or teas	☐ Alcohol use: Glass/day

Other relevant medical history:

9. Completed By

Name:	Signature:	Date (day/month/year):