REPUBLIC OF LIBERIA
LIBERIA MEDICINES & HEALTH PRODUCTS REGULATORY AUTHORITY (LMHRA)
NATIONAL PHARMACOVIGILANCE CENTER

SUSPECTED ADVERSE DRUG REACTION REPORTING FORM

LMHRA

(A) PATIENT INFORMATION				
Patient Initials:	Age:	Sex:	Weight (Kg):	Height (ft):

(B) SUSPECTED ADVERSE DRUG REACTION	
Description of Reaction	Relevant medical history
Reaction Start Date:	Reaction Stop Date:

(C) MEDICATION(S)/PRODUCT(S) USED DURING THE PERIOD

Name of Item (INN & Branded)	If vaccine	Batch No	Manufacturer	Dose used	Route of Administration	Date Treatment Started	Date Treatment Ended	Motive of treatment	Ticksuspected/other drug

Checklist if Self-medication ☐ Pharmacodependence ☐ Therapeutic error ☐
Vaccine Batch #: _____ Diluent Batch #: _____
Place of Vaccination: _____ Public ☐ Private ☐ Campaign ☐ Date: _____

Seriousness of the reaction:
☐ Death (dd/mm/yy): _____ ☐ Disability
☐ Life threatening ☐ Required intervention to permanent impairment or disorder
☐ Hospitalization – initial or prolonged ☐ Others (Specify): _____

(D) OUTCOME
☐ Fatal ☐ Continuing ☐ Recovering
☐ Recovered (date): ☐ Unknown ☐ Other (specify): _____
Please write any additional information relevant to the reaction in the space below:

(E) REPORTER'S INFORMATION
Name of Reporter: _____ Phone No: _____
☐ Pharmacist ☐ Physician ☐ Physician Assistant ☐ Nurse ☐ Widwife ☐ Other (specify): _____
Email address: _____ County: _____ District: _____
Health facility: _____ Department: _____
Date: _____ Signature: _____

THANKS FOR TAKING YOUR TIME TO REPORT