Adverse Event Reporting Form

Mendine Pharmaceuticals Pvt. Ltd.

1. Reporter Details:			
Reporter name:		Occupation:	
Address:			
Contact Information:			

2. Patient Details:					
Patient Name or Initials:		Gender: (M/F/U)		DOB: (DD/MMM/YYYY)	
Height (cm):		Weight (kg):		Age:	

Past medical history: (eg: seizure, diabetes, asthma, surgery etc.)			**Other relevant medical information:** (eg: smoking, drinking, pregnancy etc.)		
Medical history	Start date	Stop date	Medical history	Start date	Stop date

3. Suspect Product Details:						
Suspect Product Name:	Start Date (DD/MMM/YYYY)	Stop Date (DD/MMM/YYYY)	Dose / Frequency	Batch number /Expiry date	Route of Admin	Lack of efficacy

4. Concomitant Product Details:

Concomitant Product Name:	Start Date (DD/MMM/YYYY)	Stop Date (DD/MMM/YYYY)	Dose / Frequency	Batch number /Expiry date	Route of Admin	Lack of efficacy

5. Adverse Event Details:

Adverse Event	Start Date (DD/MMM/YYYY)	Stop Date (DD/MMM/YYYY)	Outcome	Corrective Treatment (if yes, please specify)

Brief Description Of The Event:

6. Seriousness:	
Caused Death	
Required or prolonged hospitalization	
Life-threatening	
Significant disability or incapacity	
Congenital anomaly/ birth defect	
Other medically serious condition	

Date of Death: (DD/MMM/YYYY)
Autopsy done: (Y/N/U)
Autopsy Result (If available):

Lab Test Name	Reference range	Actual value	Unit	Additional comment (free text)

Treating Physician Name:		Facility Name:	
Address:			
Contact number:			

Type of report:	
Initial	
Follow-up	

After completion, please send the document:
Mendine Pharmaceuticals Pvt. Ltd.
Pharmacovigilance Department
Registered Office- 36 A & B Alipore Road, Kol-27.

Information Receive Details:

Date of information received by manufacturer: D D M M M Y Y Y Y

Information received by (company employee name):

Designation:

For Adverse Event Reporting:
Please call us on: 1800-419-1417
Or e-mail us on: pv.india@mendine.com