**Fill in as much of this form for yourself or someone else and don’t worry if you don’t know everything.**

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| **PART ONE: About the side effect** |
| **Tell us what happened:** |  |
| **When did it happen?** |  |
| **How bad were the suspected side effect(s)?** Choose the option that best describes how bad the side effects were. |
| [ ]  Mild/unpleasant  | [ ]  Bad enough to affect everyday activities | [ ]  Bad enough to see GP/pharmacist/nurse  |
| [ ]  Bad enough to be admitted to hospital  | [ ]  Caused serious illness | [ ]  Caused death  |
| **How is the person feeling now?** Choose the option that best describes whether the person still has the side effects. |
| [ ]  Better (no more side effects)  | [ ]  Still recovering/getting better | [ ]  Still the same  |
| [ ]  Getting worse  | [ ]  Other, please specify: |  |
| **If it is better or getting better, when did the person start to feel better?**  |
| **Is there anything else you can tell us about the side effect?** For example, did the person have to get any other treatment for the side effect? Is this the first time the person had this or a similar side effect?  |

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| **PART TWO: About the medicine(s) that might have caused the side effect** |
| **Name of the problem medicine(s):** Include as many names as you can see on the container or label. |
|  |
| **How much was taken?** For example, one 500 mg tablet twice a day or apply to skin three times daily. |
|  |
| **Where did the medicine(s) come from?** |
| [ ]  Prescription  | [ ]  Bought in pharmacy | [ ]  Bought in supermarket  | [ ]  Other (eg, petrol station, internet)  |
| **What illness or problem was the medicine(s) taken for?**  |
| **Date the person first started taking the medicine(s):** Approximate date if actual date not known. |  |
| **Date the person stopped taking the medicine(s):** If applicable. |  |
| **Was the medicine(s) stopped because of the side effect(s)?**  | [ ]  Yes | [ ]  No |

**PTO**

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| **PART THREE: List other medicines or dietary supplements the person is taking**Fill in this section if you or the person you are reporting for were taking any other medicines at the same time. Please add more rows or attach an extra sheet of paper if you need to give further details. Dates can be approximate.  |
| **Name of other medicine(s)** | **How much was taken?**  | **Date started** | **Date stopped** |
|  |  |  |  |
|  |  |  |  |
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| **PART FOUR: About the person who had the side effect** |
| **Who had the side effect?**  | [ ]  You | [ ]  Your child | [ ]  Someone else, please specify:  |
| **Name or initials:**  |  | **Age at time of suspected side effect:**  |  |
| [ ]  Male | [ ]  Female | **Weight:** |  | **Height:** |  |
| **Is there anything else we should know?** For example, other medical conditions or allergies. |

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| **PART FIVE: About you (the person filling out the form)** |
| **Name:**  |  |
| **Contact details:**  | **Date:**  |  |
| **Can Medsafe contact you to ask for further information if needed?**  | [ ]  Yes | [ ]  No |

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| **PART SIX: About your doctor (optional)** |
| **Doctor’s name:** |  |
| **Practice or hospital name:**  |  |
| **Would you like a copy of this report to be sent to your doctor?**  | [ ]  Yes | [ ]  No |
| **Do we have permission to contact your doctor directly?**  | [ ]  Yes | [ ]  No |

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| **PART SEVEN: Feedback** |
| **How did you find filling this form?**  |
| [ ]  Extremely easy | [ ]  Very easy | [ ]  Moderately easy  | [ ]  Not so easy  | [ ]  Not at all easy  |
| **How long did it take to fill in the form?** |  |
| **How can we improve this form?** |   |