



Use blue or black ink. Complete all the lines marked with \* and give as much other information as you can

## 1 About the suspected side effect

\* **What were the symptoms of the suspected side effect, and how did it happen?** If there isn't enough space here, attach an extra sheet of paper.

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**How bad was the suspected side effect?** Tick the box that best describes how bad the symptoms were.

\*  Mild  Unpleasant, but did not affect everyday activities  Bad enough to affect everyday activities  Bad enough to see doctor  
 Bad enough to be admitted to hospital  Caused very serious illness  Caused death  Other \_\_\_\_\_

**When did the side effect start?**

**How is the person feeling now?** Tick the box that best describes whether the person still has symptoms of the suspected side effect.

\*  Better (no more symptoms)  Getting better  Still has symptoms  More seriously ill  Died  Other

**Can you give any more details?** For example, did the person take or receive any other treatment for the symptoms?  
 Did they stop taking the medicine as a result of the side effect?

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## 2 About the person who had the suspected side effect

**Who had the suspected side effect?**

\*  You  Your child  Someone else

**Is the patient pregnant?**

Yes  No  Unknown  N/A

**Information about the person** Supply as much information as you can, even if you prefer not to give a name.

First name or initials \_\_\_\_\_ Family name \_\_\_\_\_  Male  Female

\* Age \_\_\_\_\_ Weight \_\_\_\_\_  kg  stones/pounds Height \_\_\_\_\_  metres  feet/inches

**Any other relevant information?** For example, does the patient have any medical conditions or allergies? If the patient is pregnant, please provide date of last menstrual period and as much information as you can about this and any previous pregnancies.

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### 3 About the medicine(s) which might have caused the side effect

Give details of the medicine you suspect of causing the side effect.

\* **Name of the medicine** \_\_\_\_\_  prescription  bought in pharmacy  bought elsewhere

Dosage (for example, one 250 mg tablet, twice a day) \_\_\_\_\_  bought on the internet

What was it taken for? \_\_\_\_\_

Start date: \_\_\_\_\_ End date: \_\_\_\_\_ Did you stop because of side effects?  Yes  No

If you (or the person you're reporting for) were taking any other medicine at the same time (which might have caused an interaction), give details of it. If you need to give details of more than one other medicine, attach an extra sheet of paper.

**Name of other medicine** \_\_\_\_\_  prescription  bought in pharmacy  bought elsewhere

Dosage (for example, one 250 mg tablet, twice a day) \_\_\_\_\_  bought on the internet

What was it taken for? \_\_\_\_\_

Do you think this medicine might also have caused the side effect?  Yes  No  Possibly

Start date: \_\_\_\_\_ End date: \_\_\_\_\_ Did you stop because of side effects?  Yes  No

**Have you taken any other medicines or herbal remedies (as well as the above) within the last 3 months?**  Yes  No

### 4 About your doctor (optional)

**Would you like a copy of this report to be sent to your doctor?**

Yes  No **If Yes, give the doctor's name and address.**

Doctor's name \_\_\_\_\_

If you want us to send a copy of this report to any other healthcare professional, attach a separate sheet with their contact details.

Address \_\_\_\_\_

**If we need more medical information** (such as test results), do we have your permission to contact your doctor directly for it?

Yes  No

Postcode \_\_\_\_\_

### 5 About you – the person making the report

**We need contact details** — please supply a full postal address, even if you prefer not to give a phone number or email address.

\* Title \_\_\_\_\_ First name or initials \_\_\_\_\_ Family name \_\_\_\_\_

\* Address \_\_\_\_\_

\* \_\_\_\_\_ Postcode \_\_\_\_\_

Telephone number \_\_\_\_\_ Email address \_\_\_\_\_

**Please sign and date this form**

I agree that the Medicines and Healthcare products Regulatory Agency (MHRA) can contact me to discuss the suspected side effect, and to ask for more information that might help understanding of the case.

\* Signed \_\_\_\_\_ Date \_\_\_\_\_