



Report can be returned by fax to 2572 4570

For follow-up report (see Guidance Notes),  
please provide ADRMU Ref. No.: \_\_\_\_\_

**Department of Health**  
**Adverse Drug Reactions (ADR) Report Form**

**Please read the following instructions:**

1. Please read the Guidance Notes for ADR Reporting before completing the ADR report form.
2. This report form is used for voluntary report of all suspected ADR. There is no need to put down the full name of the patient.
3. ADR can be briefly described as a noxious and unintended response to a drug or vaccine when the normal dose is used.
4. Please provide information to every section. Information of individual reporter will be treated in strict confidence.
5. For further enquires, please contact the ADR Monitoring Unit of Pharmaceutical Service of the DH at 2319 8482.

**Section (A): Patient Information**

Patient initials or ref. no.: \_\_\_\_\_ Weight (if known): \_\_\_\_\_ kg  
Sex: M/F\* Date of birth: (dd/mm/yyyy) / / or age (at last birthday): \_\_\_\_\_  
For female: Is she pregnant? Yes/No\*

**Section (B): About the Adverse Drug Reaction**

Date of onset of ADR: (dd/mm/yyyy) / /

Description: \_\_\_\_\_

ADR category (for vaccine related ADR only):

Allergic reaction  Local reaction  Systemic reaction  Neurological disorders

Severity:

Life threatening  Hospitalised on: (dd/mm/yyyy) / /  Hospitalisation NOT required

<b>All Drug Therapies/Vaccines Prior to ADR</b> (Please use trade names and, for vaccine, indicate batch number. Please circle the suspected drug.)	<b>Daily Dosage</b> (dose number for vaccines e.g. 1 <sup>st</sup> DTP)	<b>Route</b>	<b>Date Begun</b>	<b>Date Stopped</b>	<b>Reason for Use</b>

**Section (C): Treatment & Outcome**

Treatment of ADR :  No  Yes. Details: \_\_\_\_\_

Outcome:  Recovered  Not yet recovered  Unknown  Died on: (dd/mm/yyyy) / /

Sequelae:  No  Yes:  Persistent disability  Birth defect  Medically significant events

Details: \_\_\_\_\_

Remarks (allergies or other relevant history): \_\_\_\_\_

**Section (D): Reporter Details**

Name of Doctor/Chinese medicine practitioner/Dentist/Pharmacist\*: \_\_\_\_\_

in private/public\* service.

Correspondence Address \_\_\_\_\_

Date: \_\_\_\_\_ Tel. no.: \_\_\_\_\_ Fax. no.: \_\_\_\_\_ Email: \_\_\_\_\_

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Affix  
Stamp

**To: ADR Monitoring Unit  
Pharmaceutical Service  
Department of Health  
3/F, Public Health Laboratory Centre  
382 Nam Cheong Street, Kowloon**

Please fold inside along the dotted line and seal the edge