



**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. As limited space is provided, please use another page for additional information if necessary.
6. For further enquires, please contact the ADR Monitoring Unit of Drug Office of the DH at 2319 2920.

**Section (A): Patient Information**

Patient initials or ref. no.: \_\_\_\_\_ Sex:  M  F: Pregnant?  No  Yes  Unknown  
 Weight (if known): \_\_\_\_\_ kg Date of birth: (dd/mm/yyyy) / / or age (at last birthday): \_\_\_\_\_  
 Ethnic group:  Chinese  Asian  African  Caucasian  Eurasian  Unknown  Others \_\_\_\_\_

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

Date of onset of ADR: (dd/mm/yyyy) / /  
 Description of event: \_\_\_\_\_

ADR category (for vaccine related ADR only):

- Allergic reaction  Local reaction  Systemic reaction  Neurological disorders

Severity (can tick more than 1 box if appropriate):

- Life threatening  Prolonged Hospitalization  Hospitalized on: (dd/mm/yyyy) / /  
 Hospitalization NOT required

Laboratory result (if applicable):

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

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

Treatment of ADR:  No  Yes. Details (including dosage, frequency, route, duration) \_\_\_\_\_

Laboratory result (if applicable): \_\_\_\_\_

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

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

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

Allergies or other relevant history (including medical history, liver/kidney problems, smoking, alcohol use etc)

**Section (D): Reporter Details**

Name: \_\_\_\_\_ Sector of service:  Private  Public

Occupation:  Doctor  Chinese medicine practitioner  Dentist  Pharmacist  Nurse  Others \_\_\_\_\_

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

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

Also report to:  Manufacturer  Distributor/Importer  Others \_\_\_\_\_ Date of this report: \_\_\_\_\_

Please seal the edge

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Please  
Affix  
Stamp

**To: ADR Monitoring Unit  
Drug Office  
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