Thame
Where quality is paramount

CIOMS FORM

SUSPECT ADVERSE DRUG REACTION REPORT

For office use only

Report Type: Initial: ☐ Follow Up: ☐	Date Received:	Adverse Event Ref:	QC Check Y/N: Initials: QC Date:

PATIENT DETAILS:

Initials:	Age:	Sex (M/F):	Weight:	Date of Birth:	Hospital Ref.

If female, is patient pregnant? Y/N	If yes, date of last menstrual period	Expected delivery date?

SUSPECTED DRUG(S):

Drug/Brand Name	Route of Admin	Daily Dosage	Indication	Date Started	Date Stopped	Is the reaction related to this drug? (Y/N)

SUSPECTED ADVERSE REACTION(S):

Please describe the reaction(s) and any treatment given:	Outcome: Recovered ☐ Recovering ☐ Continuing ☐ Unknown ☐

Do you consider the reaction to be serious? (Y/N)	Date reaction started:	Date reaction stopped:

Reason for Seriousness:

Patient Died ☐ Disability/Incapacity ☐ Life Threatening ☐ Medically Significant ☐ Involved/ Prolonged Hospitalisation ☐ Congenital Abnormality ☐

CONCOMITANT MEDICATION (incl. herbal or self medication):

Drug Name	Route of Admin	Daily Dosage	Indication	Date Started	Date Stopped	Is the reaction related to this drug? (Y/N)

ADDITIONAL INFORMATION RELEVANT TO THIS EVENT *(e.g. medical history, social history)*:

REPORTER DETAILS:

Title, Name & Surname:	Speciality:	Date:
Postal Address:	Email:	Tel No.