Report form adverse reaction
(Please fill out as completely as possible)

Confidential

Number: **Report ID:**

DESCRIPTION SUSPECTED ADVERSE REACTION			
START DATE ADVERSE REACTION	DAY	MONTH	YEAR
	Select	Select	Select
IF USED LESS THAN ONE DAY	HOURS	MINUTES	
	Select	Select	
Has the adverse event led to one of the following serious situation			
◯ yes ◉ no	☐ decease ☐ life threatening ☐ hospitalization ☐ congenital abnormality ☐ permanent disability ☐ other severe abnormalities		
FILL IN BELOW: COURSE AND SUPPLEMENTARY NOTES			

USED MEDICATION			
Medicine:			
MAH:		Country of origin:	Select
DATE OF ADMINISTRATION	DAY	MONTH	YEAR
	Select	Select	Select

DATA CLIENT			
DATE OF BIRTH	DAY	MONTH	YEAR
	Select	Select	Select
SEX	☐ MALE	☐ FEMALE	
WEIGHT	KG	PREGNANCY?	Yes ◯ No ◉
LENGTH	CM		
MEDICAL HISORY			

DATA NOTIFIER	
NAME	
ADDRESS	
POSTAL CODE	
PLACE	
PHONE NO.	
E-MAIL	
Relationship to client	Select

ANNEXES
Please add all annexes and possible additional information.
Please mention the documents you sent along:

SEND THIS FORM TO:

Orly Pharma BV, St. Jansweg 15, 5928 LW Venlo
Attn. Quality Management
By e-mail: quality@orlypharma.com

Signature

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