Drug Safety Monitoring Programme, Pharmacy Board of Sierra Leone, Ministry of Health and Sanitation.

MASS DRUG ADMINISTRATION (MDA) REPORTING FORM FOR SUSPECTED ADVERSE DRUG REACTIONS

1. PATIENT DETAILS

*.Patient's name:		Address:	
*.Sex:	*.Age(months/years):	Height:(cm)	Weight:(kg)
Health Facility			

2. DETAILS OF DRUGS

*.Name:		*.Strength:
*.Daily Dose:	*.Start date:	End date:
Therapeutic indication:		Route of administration:
Name and Address of Manufacturer:		

3. DETAILS OF ADVERSE EVENTS

*.Description of reaction experienced by patient:

*.Date/time reaction started	Date/time reaction stopped	Was patient admitted ☐ Yes ☐ No	Duration of admission (hours/days)

4. DRUGS TAKEN CONCOMITANTLY /IN THE LAST 3 MONTHS PRIOR TO THE REACTION.

All concomitant drugs including self- medication and herbal preparations

Brand or Generic Name:	Daily dose	Route of Administration	Date started	Date Stopped	Reasons for Use

Action taken	**Outcome**	**Treatment of reaction**
☐ *Drug withdrawn* ☐ *Dose increased* ☐ *Dose reduced* ☐ *Dose not changed* ☐ *Unknown*	☐ *Recovering/resolving* ☐ *Recovered/resolved* ☐ *Recovered with sequelae* ☐ *Not recovered*	

*5. *.REPORTER DETAILS*

Name:	
Designation:	
Date:	Telephone No:

Note: Fields marked (*.) are mandatory