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☐ *Drug withdrawn* ☐ *Dose increased* ☐ *Dose reduced* ☐ *Dose not changed* ☐ *Unknown*	☐ *Recovering/resolving* ☐ *Recovered/resolved* ☐ *Recovered with sequelae* ☐ *Not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

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PATIENT/CONSUMER 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

- ☐ *Drug withdrawn*
- ☐ *Dose increased*
- ☐ *Dose reduced*
- ☐ *Dose not changed*
- ☐ *Unknown*

Outcome

- ☐ *Recovering/resolving*
- ☐ *Recovered/resolved*
- ☐ *Recovered with sequelae*
- ☐ *unknown*

Treatment of reaction

*5. *.REPORTER DETAILS*

Name:

Designation:

Date: Telephone No:

Note: Fields marked (*.) are mandatory