PHARMACOVIGILANCE PROGRAMME FOR SIDDHA DRUGS

Reporting form for Suspected Adverse Reactions for Siddha Drugs

Please note: i. All consumers / patients and reporters' information will remain confidential.

ii. It is requested to report all suspected reactions to the concerned, even if it does not have complete data, as soon as possible.

Peripheral center code: State: Tamil Nadu

1. Patient / Consumer identification (Please complete or tick boxes below as Appropriate)

Name:	**Father Name:**
Patient/Record No:	**Date of Birth/Age:** years,
Ethnicity:	**Occupation:**
Sex:	**Weight: kg**
***Dhegam*:**	
Address: (With Phone number)	

2. Description of the suspected Adverse Reactions (Please complete boxes below)

Date and time of Initial observation:	**Season:**
Description of reaction:	**Geographical area:**

3. List of medicines / Formulations including drugs of other systems used by the patient during the reporting period:

Medicine	Daily dose	Route of Administration & Vehicle/Adjuvant	Date		Diagnosis for Which medicine taken
			Starting	Stopped	
Any other system of medicine					

4. Brief details of the Siddha Medicine which seems to be toxic:

A. Details	Drug – 1	Drug – 2	Drug – 3
a) Name of the medicine			
b) Manufacturing Unit and Batch no & Date			
c) Expiry date			

d) Purchased and obtained from			
e) Composition of the formulation / part of the drug used			

B. Dietary restrictions if any:

C. Whether the drug is consumed under institutionally qualified medical supervision or used as self-medication.

D. Any other relevant information

5. Treatment provided for adverse reaction:

6. The result of the adverse reaction / side effect / untoward effects:
(Please complete the boxes below)

Recovered:	Not recovered	Unknown	Fatal	If fatal Date of death
Severe:	Reaction abated after drug stopped:			
	Reaction reappeared after re introduction:			
Was the patient admitted to hospital? If yes give name and address of hospital				

7. Any Laboratory investigations done to evaluate other possibilities? If yes specify:

8. Whether the patient is suffering with any chronic disorders?

Hepatic Renal Cardiac Diabetes Malnutrition

Any others:

9. H/O previous allergies/ Drug reactions:

10. Other illness (Please describe):

11. Identification of the reporter:

Type (Please tick):	Doctor ☐ Staff Nurse ☐ Pharmacist ☐
	Patient ☐ By stander ☐ Legal representative ☐ Guardian ☐
Name:	
Address: (With Phone number)	
Telephone/ E mail if any:	

Signature of the reporter