**Patient** (at least one of the characterizations is necessary)

|  |  |
| --- | --- |
| Initials [first name\_last name]:  |  |
| Date of birth [dd\_mm\_yyyy]: |  |
| Age [years]:  |  |
| Sex: | ⃝ male ⃝ female |

**Reporter** (if reporter wants to stay anonymous, just note his relation to the patient, e.g. health professional/relative)

|  |  |
| --- | --- |
| Name |  |
| Telephone |  |
| e-mail |  |
| ⃝ reporter wants to stay anonymous |
| ⃝ health professional 🡪 ⃝ doctor ⃝ pharmacist ⃝ nurse ⃝ ………………..⃝ non health professional (e.g. husband/wife, other relative) ………………………………….. |

**Adverse Event**

|  |  |
| --- | --- |
| Adverse Event (description): |  |
| Duration of AE | …….. days or from ………………… to ………………… |
| Outcome: | ⃝ resolved ⃝ improved ⃝ ongoing ⃝ unknown |

**Suspected drug**

|  |  |
| --- | --- |
| Suspected drug(s):  |  |
| Therapy duration: | …….. days or from ………………… to ………………… |
| Concomitant medication(s): |  |
|  |
|  |
|  |

**Narrative / Additional information**

|  |
| --- |
| Narrative:  |

**Date of receipt**  …………………………………………………..

**Please send to: pv@ftrenka.com**