

Adverse Reaction Form

Please sent this document within 24 hours to pharmacovigilance@archemin.eu;
Tel. +32 15 28 74 18; Fax: +32 15 34 78 38

PART I

Contact details of the notifier of the adverse reaction

Name of the delegate :

Name of the notifier (first name followed
by last name) :

Profession : General practitioner Pharmacist Patient Specialist (*)

(*) Precise:

Institution :

Department :

Other Precise :

Phone :

E-mail :

PART II

DESCRIPTION OF THE ADVERSE REACTION*

**Food
supplement:**

Dosage :

Form :

Patient's initials:

Age :

Gender :

*It concerns :

- an adverse event
- the transmission of an infection
- misuse
- an abuse/or addiction
- administration error
- overdose
- professional exposure
- effect following stopping
- lack of efficacy

Symptom(s) and/ or diagnosis:

Date of start and end (dd/mm/yyyy): or

Duration of the adverse reaction :