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*		
Medical Device:	**Dosage** :	**Form** :
Patient's initials:	**Age** :	**Gender** :

*It concerns :	**Symptom(s) and/ or diagnosis:**
☐ an adverse event ☐ the transmission of an infection ☐ misuse ☐ an abuse/or addiction ☐ administration error ☐ overdose ☐ professional exposure ☐ effect after stopping ☐ lack of efficacy	**Date of start and end (dd/mm/yyy):** or **Duration of the adverse reaction :**