



Yellow Card



Suspected Adverse Event Reporting Form

Identities of reporter, patient, institution, and product trade name(s) will remain confidential

* Mandatory Information

Please mark with a tick (✓) where applicable

Report No:.....

(For DGDA Use Only)

Date of Report:

A. Patient Information:

Name:

* Age:

* Mobile No:

* Sex:

Pregnant: Yes/No

B. Suspected Adverse Event Information:

Type of event: Serious

Not Serious

* Describe event including relevant tests and laboratory results:

* Event start Date:

* Event stopped Date:

Was the adverse event treated? Yes/No

If yes, please specify:

Actions taken after reaction:

Dose stopped

Dose reduced

No action taken

Did the reaction subside after stopping/
reducing the dose of the suspected product?

Yes/No

Status of the serious adverse event:

Hospitalization or prolongation of hospitalization

Life threatening

Disability or permanent damage

Congenital anomaly/ Birth defect

Death (Date of death:.....)

Previous disease history:

Allergies

Hypertension

Liver or kidney problems

Diabetes

Others (Please specify)

* Outcomes attributed to the adverse event: Recovered/ Not recovered/ Unknown

Reporters' opinion if applicable: Less or not effective drug/ Medication error/ Quality issues / Others

C. Suspected Drug Information:

Brand/ Trade name:

* Generic name:

* Indication:

Whether there have been any side effects from
this medicine before? Yes/No

* Medication start date:

* Medication end date:

* Dosage form:

Batch number:

Concomitant Medicine Information:

Brand/Trade name

Generic name

Indication

Dosage form

Strength & Frequency

D. Reporter Information:

* Name:

* Mobile phone:

* Date of report submission:

Occupation:

Workplace:

Address:

Postal Address:

Director (Pharmacovigilance)

Directorate General of Drug Administration

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