"PHARMACOVIGILANCE"
HEALTH BRANDS
DRUG MONITORING FORM

Report drug failure and adverse reactions with medications and suspected counterfeit product

An adverse reaction occurs when the patient outcome is:
Death, life-threatening (real risk of dying), hospitalization (initial or prolonged), disability (significant, persistent or permanent), congenital defect, permanent impairment, allergic reactions, gastrointestinal distress.

Report even if:

- You're not certain whether the product caused the adverse reaction
- You don't have all the details

Who can report?
Any healthcare professional (Physician, Pharmacist, Dentist, Nurse)
Any patient who has experienced an adverse drug reaction

Where to report:
After completing, please return this form to: Health Brands Ltd
39 Hagley Park Road, Kingston
Tel: (876) 906-5498
Email: patientsupport@healthbrandsjm.com

For additional information or for reporting online please visit our website at www.healthbrandsjm.com

Our Privacy Policy

Health Brands Limited is committed to protecting personal data and protecting personal information in connection with adverse event reports, product quality complaints and medical information enquiries, which will be in accordance with the Data Protection Act of Jamaica.

This Privacy Statement is addressed to

- Reporters of adverse events, providing safety information about our products, requesting medical information and submitting quality complaints; and
- Persons who are the subject of adverse events, special care cases, requesting medical information and product quality complaints.

"PHARMACOVIGILANCE" DRUG MONITORING FORM

A. PATIENT DETAILS

1. Patient Initials: (First, Last)	2. Gender: ☐M ☐F	3. Date of Birth / Age: (yyyy/mm/dd)	4. Ethnicity	5. Weight:(Kg)	6. Height:(cm)

B. SUSPECTED DRUG EVENT

7. Outcomes attributed to use of drug (check all that apply):	8. Describe event or problem	9. Date event started (yyyy/mm/dd)
☐ Failure of therapy ☐Allergy ☐ Disability ☐Life threatening ☐ Hospitalisation ☐ Death_____ yyyy/mm/dd ☐ Other (describe)_____		10. Date event ended (yyyy/mm/dd)

11. Describe action taken in response (e.g., drug changed, prolonged-therapy, increased dose)	12. Describe other relevant history including abnormal laboratory test results, days of hospitalization.

C. DRUG INFORMATION

13. Name of suspected drug (give specific name on package)	14. Dose & Route	15. Indication	16. Batch number if known
17. Name of other drugs taken (give specific name on package)	**18. Dose & Route**	**19. Indication**	**20. Batch number if known**

D. REPORTING HEALTH PROFESSIONAL INFORMATION

21. Profession: _____	24. Telephone: _____
22. Name: _____	25. Fax: _____
23. Address: _____	26. Email_____

27. Also reported to:

Signature Date (yyyy/mm/dd)

FOR OFFICIAL USE ONLY Code No

Received by:	Action taken:
Date received:	

Completed forms may be delivered to:

Health Brands Ltd
39 Hagley Park Road, Kingston
or emailed to:
patientsupport@healthbrandsjm.com