



Provincial Safety Management System Adverse Drug Reaction Form

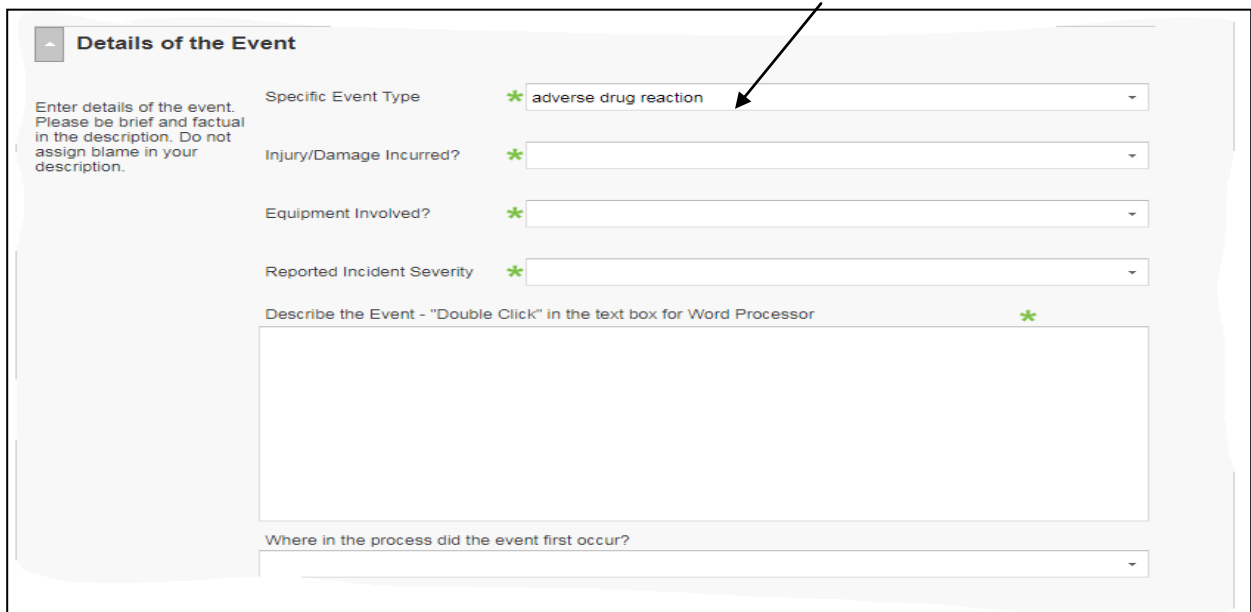
Please be advised that Adverse Drug Reactions are required/mandatory reporting to Health Canada.

Step 1

When reporting an **Adverse Drug Reaction**, please select the Medication Form . You must complete all mandatory fields marked with a green asterisk (*).

Step 2

Under the **Specific Event Type**: Select **Adverse Drug Reaction**



Details of the Event

Enter details of the event. Please be brief and factual in the description. Do not assign blame in your description.

Specific Event Type * adverse drug reaction

Injury/Damage Incurred? *

Equipment Involved? *

Reported Incident Severity *


Describe the Event - "Double Click" in the text box for Word Processor *

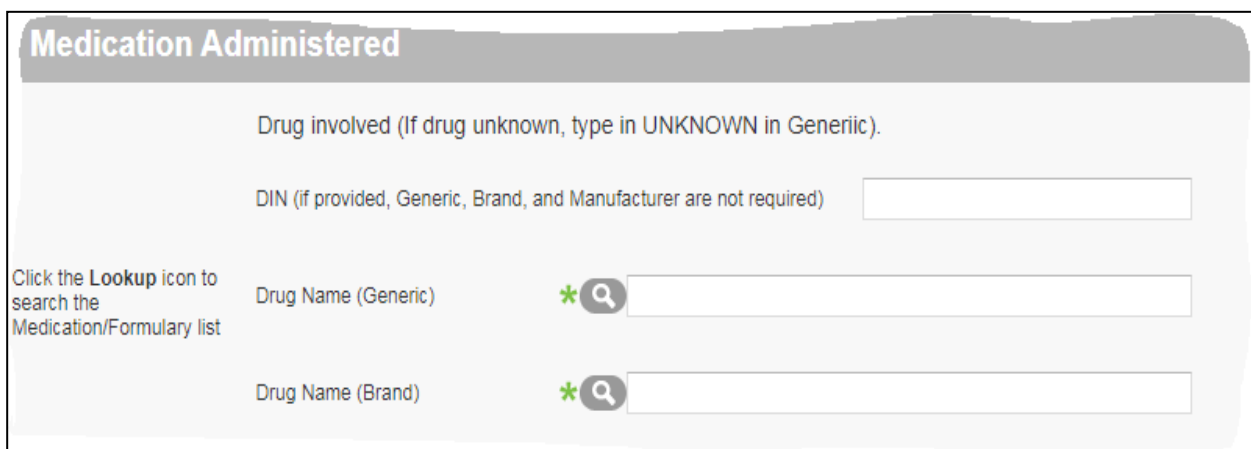
Where in the process did the event first occur?

Step 3

Under **Medication Ordered**: It is a Mandatory field. Please put N/A if there was NO Medication Ordered into the required Mandatory Field.

Under **Medication Administered**: If you know the DIN please enter. If not, please select

the Drug Name (Generic) OR Drug Name (Brand) search icon  and look up Medication and complete all mandatory fields.





Medication Administered

Drug involved (If drug unknown, type in UNKNOWN in Generic).

DIN (if provided, Generic, Brand, and Manufacturer are not required)

Click the Lookup icon to search the Medication/Formulary list

Drug Name (Generic) * 

Drug Name (Brand) * 

Medication Administered

Dosage

Dose Type

Other information

Route Manufacturer *

Lot # Expiry Date:

Strength

Serious Adverse Drug Reaction Reporting

Identifying Code for Urgent Public Health Need Drugs

Did you also report to the manufacturer? *

Product Start Date * Product End Date

Step 4

Complete all mandatory fields on the Medication form and submit form when completed.

Serious Adverse Drug Reaction Report

General Information

Type of Report *

Hospital Contact First Name *

Hospital Contact Last Name *

Hospital Contact Phone No * (____) ____-____

Reason for Seriousness *

Patient Information

Sex *

Patient Age Patient Age Unit

Known Medical Conditions And Relevant Lifestyle Factors *