REPUBLIQUE DU CAMEROUN
PAIX - TRAVAIL - PATRIE

MINISTERE DE LA SANTE PUBLIQUE

REPUBLIC OF CAMEROON
PEACE – WORK – FATHERLAND

MINISTRY OF PUBLIC HEALTH

Form for reporting adverse drug reaction(s) likely due to a drug or a health product used by humans
To be filled and returned to the provincial drug monitoring centre and to the Department of Pharmacy and Drugs
Fax: 00 237 22 23 39 33
E-mail : pharmacovigilance_cam@yahoo.fr

PATIENT TREATED :	Name (first 3 letters): _____ Given name (first letter): ___ Sex: Age: Weight: Height:	If new-born, Product taken: By the patient: ☐ By breastfeeding: ☐ By mother during pregnancy: ☐ (specify the trimester): _____

History / favourable factors: Pregnancy ☐ Alcoholism ☐ Hepathopathy ☐ Allergy ☐

Nephropathy ☐ Tobacco addiction ☐ Others (Specify) ☐ _____

SUSPICIOUS MEDICATIONS (Including vaccines, solvents and herbal medicines):

N°.	Name	Producer	Batch N°	Expiry date	Method of administration	Dosage	INDICATION/ aim of treatment	DURATION OF TREATMENT	
								Start	End
1									
2									

ASSOCIATED PRODUCTS (Including vaccines, solvents and herbal medicines):

N°.	Name	Producer	Batch N°	Expiry date	Method of administration	Dosage	INDICATION/ aim of treatment	DURATION OF TREATMENT	
								Start	End
1									
2									
3									

Has one or more products been stopped?:
Yes ☐ No ☐ No information ☐
If so, which: _____
Did reaction disappear after stopping?
Yes ☐ No ☐ No information ☐

Was one or more products re-introduced?
Yes ☐ No ☐ No information ☐
If so, did reaction reappear,
Yes ☐ No ☐ No information ☐

ADVERSE REACTION:

DATE OF OCCURRENCE	DURATION AND REACTION	SERIOUSNESS	EVOLUTION
		☐ Hospitalisation or prolongation of hospitalization	☐ Healing without after-effects
		☐ Incapacity or permanent invalidity	☐ Death induced by reaction
		☐ Involvement of vital prognosis	☐ Death unrelated to reaction
		☐ Death	☐ Subject yet to recover
			☐ Healing with after-effect
			☐ Death contributed to by reaction
			☐ Unknown

NATURE AND DESCRIPTION OF ADVERSE REACTION: (continue overleaf if necessary)

REPORTER:
Surname and given name: _____
☐ Medical doctor ☐ Pharmacist ☐ Dentist ☐ Midwife ☐ Nurse ☐ Others (specify) _____
Speciality (specify) _____
Address: _____
Tel: _____ Fax: _____ E-mail: _____
Date: _____ Signature: Stamp: