Republic of Namibia

Ministry of Health and Social Services

ADVERSE MEDICINE REACTION REPORTING FORM

Safety Yellow Form
Confidential

A) PATIENT INFORMATION

Patient initials or Hospital Reg. No.		DOB DD / MM / YYYY Age……..	Gender: ☐ Male ☐ Female	Weight (Kg):

B) ADVERSE EVENT INFORMATION

Type of report: Initial: ☐ Follow up: ☐ Write AMR ID number

DESCRIPTION OF ADVERSE EVENTS: Indicate provisional / final diagnosis of the adverse event	Date the event started:	Date the event stopped:	Action taken: (E.g. Medicine withdrawn / substituted / Dose reduced / medical treatment etc...)

Seriousness	☐ Hospitalization ☐ Disability or permanent damage ☐ Congenital anomaly / birth defect ☐ Life-threatening ☐ Other serious medical event ☐ Non serious adverse event

Relevant Laboratory tests	Test date DD / MM / YYYY	Result

Patient Outcome	☐ Recovered ☐ Recovered with sequela ☐Recovering ☐ Not recovered ☐ Unknown	Died ☐Due to reaction ☐ unrelated to reaction ☐ Reaction maybe contributory Date of death DD / MM / YYYY

RELEVANT MEDICAL HISTORY: including pre-existing medical conditions (allergies, pregnancy, alcohol use, liver problems..)

C) INFORMATION ON MEDICINES: *For vaccines please indicate the batch number*

LIST MEDICINES USED IN THE LAST 3 MONTHS TICK SUSPECTED MEDICINES ENTER FDC AS ONE MEDICINE		Strength	Frequency	Route of Admin.	Start date	Stop date or ongoing	Indication
	☐						
	☐						
	☐						
	☐						
	☐						
	☐						

D) REPORTER INFORMATION

Name (last, first)		Region		Email	
Profession		Telephone		Date	DD / MM / YYYY
Health Facility Name		Fax			

Please tick if you need ☐ *AMR forms* ☐ *Additional information*

Please note that submission of a report does not constitute an admission that medical personnel or the medicine caused or contributed to the event

Send/ Fax/Email to TIPC: Therapeutics Information and Pharmacovigilance Centre
Room 21, Basement Area, Windhoek Central Hospital. Windhoek.
Tel: 061 203 2312 Fax: 061 22 66 31/ 088 618 776. Email: info@tipc.com.na