

EU Veterinary Suspected Adverse Reaction Report Form for Veterinarians & Health Professionals

Form to be sent to: CID LINES NV Waterpoortstraat 2 8900 Ieper - BE Fax: 003257217879 E-mail: pharmacovigilance@cidlines.com					Ref. Number:	
Phone: 0032475988363 Website: www.cidlines.com						
IDENTIFICATION		NAME AND ADDRESS OF SENDER			NAME & ADDRESS/REF. OF PATIENT	
Safety issue in animals <input type="checkbox"/> in humans <input type="checkbox"/> Lack of expected efficacy <input type="checkbox"/> Withdrawal period issues <input type="checkbox"/> Environmental problems <input type="checkbox"/>		Veterinarian <input type="checkbox"/> Pharmacist <input type="checkbox"/> Other <input type="checkbox"/> Phone: _____ Fax: _____			(according to national law)	
PATIENT(S)						
Animal(s) <input type="checkbox"/>		Human(s) <input type="checkbox"/> (for humans fill only age and sex below)				
Species	Breed	Sex	Status	Age	Weight	Reason for treatment
		Female <input type="checkbox"/> Male <input type="checkbox"/>	Neutered <input type="checkbox"/> Pregnant <input type="checkbox"/>			
VETERINARY MEDICINAL PRODUCTS ADMINISTERED BEFORE THE SUSPECTED ADVERSE REACTION						
(if more products are administered concurrently than the number of boxes available, please duplicate this form)						
Name of the veterinary medicinal product (VMP) administered		1	2	3		
Pharmaceutical form & strength (ex: 100 mg tablets)						
Marketing Authorisation number						
Batch number						
Route / site of administration						
Dose / Frequency						
Duration of treatment / Exposure						
Start date						
End date						
Who administered the VMP? (veterinarian, owner, other)						
Do you think that the reaction is due to this product?		Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Has the Marketing Authorisation Holder (MAH) been informed?		Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		

SUSPECTED ADVERSE REACTION DATE / /	Time between administration and event in minutes, hours or days 	Number treated _____ Number reacted _____ Number dead _____	Duration of the adverse reaction in minutes, hours or days
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DESCRIPTION OF THE EVENT (*Safety issues in animals or Safety issues in humans / Lack of expected efficacy / Withdrawal period issues / Environmental problems*) - Please describe:

Indicate also if the reaction has been treated, how and with what and what was the result?

OTHER RELEVANT DATA (ATTACH FURTHER PAPERS IF NECESSARY e.g. investigations carried out or ongoing, a copy of medical report for human cases)

HUMAN CASE
If the reported case refers to a human being, please also complete the details of exposure below

• Contact with treated animal	<input type="checkbox"/>				
• Oral ingestion	<input type="checkbox"/>				
• Topical exposure	<input type="checkbox"/>				
• Ocular exposure	<input type="checkbox"/>				
• Injection exposure	<input type="checkbox"/>	finger <input type="checkbox"/>	hand <input type="checkbox"/>	joint <input type="checkbox"/>	other <input type="checkbox"/>
• Other (deliberate ...)	<input type="checkbox"/>				

If you do not agree that your complete name and address are sent to the MAH if further information requested, please tick the box:

Date:	Place:	Name and signature of sender:
Contact point (phone) (if different from the number on page 1)		