





<b>C. DRUG INFORMATION</b>	
Product Name	Brand Name
	Generic Name
Therapy Dates	From
	To
Manufacturer	
Batch / Lot Number	
Expiry Date	
Dose	
Route of use	
Frequency	
Indication	

<b>D. CONCOMITANT DRUGS</b>					
Drug Name (s)		Dose	Therapy Dates		Reason for Use
Brand Name	Generic Name		From (DD/MM/YYYY)	To (DD/MM/YYYY)	
ACTION TAKEN WITH SUSPECT DRUG (mark all as appropriate)					
<input type="checkbox"/> No Action Taken		<input type="checkbox"/> Withdrawn		<input type="checkbox"/> Treatment taken	
Did Reaction Disappear After Stopping of Drug ?			Did Reaction Reappeared After Restarting of Drug ?		
<input type="checkbox"/> Yes		<input type="checkbox"/> No		<input type="checkbox"/> Yes	
<input type="checkbox"/> Not Applicable		<input type="checkbox"/> Unknown		<input type="checkbox"/> No	
				<input type="checkbox"/> Not Applicable	
				<input type="checkbox"/> Unknown	
OUTCOME OF THE PATIENT / AE					
<input type="checkbox"/> Completely Recovered		Date of recovery	DD/MM/YYYY	<input type="checkbox"/> Condition still present and unchanged	
<input type="checkbox"/> Recovered with sequelae			<input type="checkbox"/> Condition deteriorated		
<input type="checkbox"/> Condition improving			<input type="checkbox"/> Death Autopsy		
			<input type="checkbox"/> No		
			<input type="checkbox"/> Yes		
ASSESSMENT OF CAUSALITY					
<input type="checkbox"/> Probable		<input type="checkbox"/> Possible		<input type="checkbox"/> Not Related	
				<input type="checkbox"/> Unknown	



<b>E. REPORTER'S INFORMATION</b>	
Name : Address : Tel. No. : Email :	Date of this Report DD/MM/YYYY
	<input type="checkbox"/> HCP  <input type="checkbox"/> CONSUMER  <input type="checkbox"/> OTHER  Signature
	Senders Contact Details : Inga Laboratories Private Limited Mahakali Road, Andheri East, Mumbai - - 400 093, INDIA. Tel.: 91-22 2820 2932 / 33, Fax: 91-22 2836 4049 E-mail: <a href="mailto:medicalservices@ingalabs.com">medicalservices@ingalabs.com</a>