

**YellowCard**

COMMISSION ON HUMAN MEDICINES (CHM)

**SUSPECTED ADVERSE DRUG REACTIONS**

If you are suspicious that an adverse reaction may be related to a drug or combination of drugs please complete this Yellow Card. For reporting advice please see over. Do not be put off reporting because some details are not known.

**PATIENT DETAILS** Patient Initials: \_\_\_\_\_ Sex: M / F Weight if known (kg): \_\_\_\_\_  
 Age (at time of reaction): \_\_\_\_\_ Identification number (Your Practice / Hospital Ref.): \_\_\_\_\_

**SUSPECTED DRUG(S)**

Give brand name of drug and batch number if known

Route	Dosage	Date started	Date stopped	Prescribed for
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**SUSPECTED REACTION(S)**

Please describe the reaction(s) and any treatment given:

Date reaction(s) started: \_\_\_\_\_ Date reaction(s) stopped: \_\_\_\_\_

Do you consider the reactions to be serious? Yes / No

If yes, please indicate why the reaction is considered to be serious (please tick all that apply):

Patient died due to reaction	<input type="checkbox"/>	Involved or prolonged inpatient hospitalisation	<input type="checkbox"/>
Life threatening	<input type="checkbox"/>	Involved persistent or significant disability or incapacity	<input type="checkbox"/>
Congenital abnormality	<input type="checkbox"/>	Medically significant; please give details: _____	

**Outcome**

Recovered	<input type="checkbox"/>
Recovering	<input type="checkbox"/>
Continuing	<input type="checkbox"/>
Other	<input type="checkbox"/>

**OTHER DRUGS (including self-medication & herbal remedies)**

Did the patient take any other drugs in the last 3 months prior to the reaction? Yes / No

If yes, please give the following information if known:

Drug (Brand, if known)	Route	Dosage	Date started	Date stopped	Prescribed for
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

**Additional relevant information** e.g. medical history, test results, known allergies, rechallenge (if performed), suspect drug interactions. For congenital abnormalities please state all other drugs taken during pregnancy and the last menstrual period.

**REPORTER DETAILS**

Name and Professional Address: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Post code: \_\_\_\_\_ Tel No: \_\_\_\_\_  
 Speciality: \_\_\_\_\_  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**CLINICIAN (if not the reporter)**

Name and Professional Address: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_ Post code: \_\_\_\_\_  
 Tel No: \_\_\_\_\_ Speciality: \_\_\_\_\_

If you report from an area served by a Yellow Card Centre (YCC), MHRA may ask the Centre to communicate with you, on its behalf, about your report. If you want only MHRA to contact you, please tick this box.

See page 10 of BNF for details on YCCs.

\* This is to enable you to identify the patient in any future correspondence concerning this report

**Please attach additional pages if necessary**