Tear along dotted line

Confidential

Patient Yellow Card report

Please fill in this form clearly in blue or black ink.

About the person completing the Yellow Card report

1 **Please tell us about yourself.**

Family name First name

Address

Postcode

Telephone number Email address

About the person who had the suspected side effect

2 **Who had the suspected side effect? (Tick one)**

You ☐ Someone else you are responsible for ☐

Your child ☐ Someone else with their agreement ☐

3 **Tell us more about the person who had the suspected side effect (you do not have to give their name).**

Family name

First name

Weight Height

Age Male ☐ Female ☐

About the medicine(s) you think caused the side effect

(If you are unsure, you can list more than one medicine. If more than two medicines, please attach separate sheets.)

4a ***Medicine 1***

Name of medicine (you can find this information on the label or pack. For herbal or complementary remedies, please list ingredients if possible).

What was the dosage of the medicine? (e.g. one 250mg tablet, three times a day, for seven days)

When was the medicine started?

What was it used for?

How did you get the medicine? (circle one)

(a) prescription, (b) bought in a pharmacy,
(c) bought in another shop,
(d) other (please describe)

In what form was the medicine used? (circle one)

(a) tablet, (b) capsule, (c) liquid medicine by mouth,
(d) cream or lotion, (e) eye drops, (f) patch, (g) injection,
(h) other (please describe)

Have you stopped taking the medicine? Yes ☐ No ☐

If Yes, when?

4b ***Medicine 2 (if necessary)***

Name of medicine (you can find this information on the label or pack. For herbal or complementary remedies, please list ingredients if possible).

What was the dosage of the medicine? (e.g. one 250mg tablet, three times a day, for seven days)

When was the medicine started?

What was it used for?

How did you get the medicine? (circle one)

(a) prescription, (b) bought in a pharmacy,
(c) bought in another shop,
(d) other (please describe)

In what form was the medicine used? (circle one)

(a) tablet, (b) capsule, (c) liquid medicine by mouth,
(d) cream or lotion, (e) eye drops, (f) patch, (g) injection,
(h) other (please describe)

Have you stopped taking the medicine? Yes ☐ No ☐

If Yes, when?

Other medicines

5 **Please tell us about any other medicines or remedies used within three months of having the suspected side effect. Please attach separate sheets if necessary.**

Name of medicine	Dosage	Date started	Date stopped	What used for

Code

Please turn over

About the suspected side effect

6 **When did the suspected side effect start?**

Has the suspected side effect stopped? Yes ☐ No ☐
If Yes, when did it stop?

7 **How bad was the suspected side effect? (Tick one)**

- ☐ Mild or slightly uncomfortable
- ☐ Uncomfortable, a nuisance or irritation, but able to carry on with everyday activities
- ☐ Bad enough to affect everyday activities
- ☐ Bad enough to be admitted to hospital
- ☐ Life-threatening
- ☐ Caused death

8 **How is the person who had the suspected side effect now? (Tick one)**

Recovered completely ☐

Recovered but with some lasting effects ☐
(please describe below)

Getting better ☐ Still has reaction ☐ Other ☐
(please describe below)

9 **Please describe the suspected side effect and any treatment received, and tell us whether the suspected side effect caused the person to stop taking the medicine. Please attach separate sheets if necessary.**

Other medical information

10 **Please tell us any other information that you think could be important, including any other medical condition or allergies that the person may have.**

Other questions

11 **Was a doctor, pharmacist or other health professional told about the suspected side effect?**
Yes ☐ No ☐ Don't know ☐

12 **If Yes, did the health professional complete a Yellow Card report?**
Yes ☐ No ☐ Don't know ☐

13 **Are you happy for the MHRA to contact you in the future to discuss the suspected side effect or ask for more information?**
Yes ☐ No ☐

If this report is about you or your child please answer **14** *and* **15** *before signing at* **16**. *If the report is about someone else, please go straight to* **16**.

14 **Would you like a copy of this report to be sent to your doctor?** Yes ☐ No ☐

15 **If we need further information (e.g. medical information or test results), do we have your permission to contact your doctor directly directly for it?** Yes ☐ No ☐

If Yes to 14 and/or 15, please give your doctor's contact details.

Doctor's name

Address

Postcode

If you would like us to send a copy of this report to another health professional, please attach a separate sheet with their contact details.

ALL REPORTS

16 Signature Date

Please return this form in the envelope provided to: Medicines and Healthcare products Regulatory Agency, CSM FREEPOST, London SW8 5BR