

**Adverse Reactions to Medicines, Vaccines and Devices  
and all clinical events for IMMP**

H1574

**PATIENT Details**

<b>Surname:</b> Renata	<b>First Name(s)</b> Jasmine	<b>NHI No:</b> FHX4152
<b>Address:</b> 28 California Drive, Totara Park, Upper Hutt		<b>Date of Birth:</b> 13/05/91
		<b>Sex:</b> <input type="checkbox"/> M <input checked="" type="checkbox"/> F

**ALL MEDICINES IN USE - ASTERISK SUSPECT MEDICINE(S)**

Medicine(s) / Vaccine(s)+batch no.	Daily Dose	Route	Date Started	Date Stopped	Reason for Use
HPV NJO2260	18 Sep 2008				
HPV NJ11440	18 Nov 2008				
HPV NH11440	17 Mar 2009				

**DESCRIPTION OF ADVERSE REACTION**

<b>Date of Onset:</b> dd/mm/yy: Please see supplemental word document.
<b>Please describe reaction here using as many lines as you need:</b> Please see supplemental word document.

**Description of Outcome of Adverse Reaction or Incident**

Recovered <input checked="" type="checkbox"/>	Not yet recovered <input type="checkbox"/>	Unknown <input type="checkbox"/>	Fatal <input checked="" type="checkbox"/>	Date of Death 22/09/2009
<b>Severe ?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>	<b>Rechallenge ?</b> No <input type="checkbox"/> Yes <input type="checkbox"/> Result:			

**OTHER FACTORS - Please circle**

Renal Disease <input type="checkbox"/>	Hepatic Disease <input type="checkbox"/>	Allergy <input type="checkbox"/>	Describe:
OTC Use? <input type="checkbox"/>	Industrial Chemicals <input type="checkbox"/>	Other Medical Conditions? <input type="checkbox"/>	

**REPORTING DOCTOR/PHARMACIST:**

Name:	Telephone: 5272011
Address: Radius, Upper Hutt	
Email address?:	Date:

Post to: Freepost 112002 The Medical Assessor Centre for Adverse Reactions Monitoring PO Box 913 DUNEDIN	Fax to: +64-3-479-7150
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