Patient Yellow Card

Patient report on suspected adverse drug reactions

If you think you or someone else has had an unwanted or harmful reaction after taking a medicine (an adverse drug reaction), we would like to know.

Please try to complete as much of the form as possible. It does not matter if you cannot complete all sections (however, you must complete the mandatory fields).

The information you give us is confidential, and it will not be given to anyone else without your permission. We ask for your contact details so that we can contact you if we need further information about the reaction.

Your Details

(*mandatory fields)

Title: Please select

*First Name

*Surname

*Address

*Town

*County

*Postcode

*Telephone

Email Address

Confirm e-mail Address

Date: 14/12/2005

About the person who had a reaction

(*mandatory fields)

*Who had the reaction? Please select one from the drop down list

*Age Years

or

Months

or

Days

*Sex Male Female

Weight(in kilograms)

About the medicine(s) you suspect caused the reaction

(details can be found on the label or packaging)

Name of medicine (brand name if known)	Dosage	How did you take the medicine?	When did you start taking the medicine?	When did you stop taking the medicine
		Please select....		
		Please select....		
		Please select....		
		Please select....		
		Please select....		

About any other medicine(s) (or herbal remedies) taken within 3 months of the reaction

(details can be found on the label or packaging)

Name of medicine (brand name if known)	Dosage	How did you take the medicine?	When did you start taking the medicine?	When did you stop taking the medicine
		Please select....		
		Please select....		
		Please select....		
		Please select....		
		Please select....		
		Please select....		
		Please select....		
		Please select....		
		Please select....		
		Please select....		

About the Reaction

Please tell us about the reaction including when it started and stopped.

Information from other sources can be pa

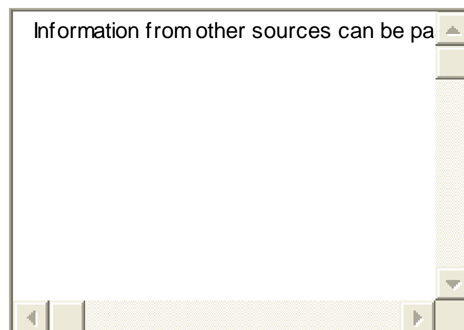
*How is the person who had the reaction now? Please select from the drop down list

* Did the person who had the reaction contact a doctor, nurse or pharmacist because of the reaction? ◯ Yes ◯ No ◯ Not Known

* Was the person who had the reaction admitted to hospital (or have to stay longer in hospital) because of the reaction? ◯ Yes ◯ No ◯ Not Known

Any further information that would help us

Including medical history, test results, known allergies etc.



Would you like us to send a copy of this report to the doctor of the person who had the reaction? ( ) Yes (•) No

Doctor's Details

(who will receive a copy of this)

First Name

Surname

Address

Town

County

Postcode

Telephone

Your child's name

(since this report is about your child, please give us their name so that your doctor will know who the report is about)

Child's First Name

Child's Surname

Submit