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| Adverse Event Form **Date received at MA department:** | **No: ART**  **Staff initials:** |

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| **1. Reporter/Veterinarian** | | |
| Date report: |  | |
| Veterinary practise: |  | |
| Name reporter: |  | Position: |
| Address |  | |
| City: |  | |
| Phone number |  | |
| **2. Animal** | | |
|  |  | |
| Name patient  (animal and last name owner): |  | |
| Animal species/breed/gender: | Species:  Breed:  Gender: | |
| Age: |  | |
| Weight: |  | |
| Physical condition  (neutered, in foal etc:) |  | |
| Condition  (relevant medical history): |  | |
| **3. Used product in adverse event** | | |
| Name product: |  | |
| Concentration (if applicable): |  | |
| Batch no: |  | |
| Expiry date: |  | |
| Doses, frequency: | Dose:        ml /  gr /  tabs /  caps /  chew *(mark what is applicable)* Frequency:  Administered by:  veterinarian /  owner :  up dosing phase OR  maintenance phase | |
| Date product used for the first time:  (first dose in course administered) | Day:       Month:       Year:  If unknown please indicate how long the patient is on the product: approx.       year(s) and       months | |
| Date & Time last administration: | **(dose that caused the onset of the adverse event):**  Day:       Month:       Year:  Time:       Dose:       ml / gr / tabs / caps / chew  (mark what is applicable) | |
| Date and time onset adverse event: | Day:       Month:       Year:  Time event became visible:  (for example: 30 minutes after administration, or 2 days after administration) | |
| Treatment continued after adverse event | Yes, as usual  Yes, with dose reduction as follows:  No | |
| **4. Other drugs taken during the time of the adverse event (when applicable) and reason** | | |
| **YES  / NO**  **If yes, please specify below:** | | |
| Name drug: |  |  |
| Batch no: |  |  |
| Doses, frequency: |  |  |
| Date of administration: |  |  |
| Reason/indication: |  |  |
| **5. Data concerning side effects** | | |
| Adverse event in **keywords** |  | |
| Narrative |  | |
| Adverse reaction treated with:  Date treated: | None  Dose reduction to  Treatment stopped  Therapeutic intervention: | |
| Response to corrective treatment: |  | |
| Outcome of adverse event:  Date of outcome: | Recovered:  Stabilized with rest symptoms  Description of rest symptoms:    Death  Other: | |
| **6. Narrative of treatment of adverse event. How and with which results?** | | |
| Laboratory data available:  Yes (please provide)  No | | |
| **7. Do you think that the reaction was caused by Artuvetrin?** | | |
| probable  possible  unlikely  unassessable | | |
| **8. Other relevant history or information** | | |
|  | | |

**Signature reporter:** **Date:**