

**CYCLOMEDICA AUSTRALIA PTY LTD
ADVERSE EVENT REPORT FORM**

IMMEDIATE ACTION TAKEN

NONE DRUG WITHDRAWN
 OTHER MEASURES TO TREAT SUSPECTED
ADVERSE DRUG REACTION Please specify _____.

RELEVANT MEDICAL HISTORY

RELEVANT MEDICAL HISTORY: _____
OTHER CONCOMITANT MEDICATION: _____

REPORTER INFORMATION

HAS THIS CASE BEEN REPORTED TO THE NATIONAL AUTHORITY OR ANY OTHER ORGANISATION? Yes NO

IF YES, TO WHOM _____

REPORTER (Name, Institution, Address, Phone, Fax, e-mail)

Physician
Patient
Pharmacist
Other
Nurse

DATE ____ / ____ / ____
 dd mm yy

SIGNATURE _____