NZ Health Trust
Protecting your Future

Suspected Adverse Reaction Report

The purpose of this form is to enable you to record for CARM (Centre for Adverse Reaction Monitoring) what you believe was an adverse reaction to a prescription medicine that you as a patient experienced.

Your pharmacy will provide on request information on potential adverse reactions that any medicine may cause.

Your Name: _____ Age: _____

Postal Address: _____

Health Professional's Name: _____ Telephone: _____

Postal Address: _____

Condition being treated:

Medication thought to be causing reaction:

Date started taking medication: / /

Did your Health Professional inform you of possible adverse reactions to this medicine? **Yes / No** *(please circle)*

Other medications you were taking at the same time:

Nature of adverse reaction(s) experienced: *Please continue on back of form if necessary→*

When did you first notice this adverse reaction? / /

Have you been back to your Health Professional about the adverse reaction? **Yes / No** *(please circle)*

Date of consultation: / /

What was your Healthcare professional's response? (*e.g. stopping or changing medicine, no action etc….)*

Please continue on back of form if necessary→

Signature: _____ Date: / /

After completing this report, please make 3 copies and send a copy to each of the following addresses;

Freepost 112002
The Medical Assessor
Centre of Adverse Reaction Monitoring
PO Box 913 **DUNEDIN 9020**

NZ Health Trust
PO Box 34-057
CHRISTCHURCH 8030

The Ministry of Health
PO Box 5013
WELLINGTON 6040

For more information email info@nzht.co.nz or check out the website at http://www.nzht.co.nz/ar