1. Reporter Details		☐ Initial ☐ Follow-up
Reporter Name:		E-mail:
Contact address:		Telephone number:
		Fax number:
Type:	☐ Physician (Specialty): _____	☐ Consumer or other non healthcare professional
	☐ Pharmacist	☐ Other (Specify) _____

If reporter is a consumer, have they informed their physician of the exposure?	☐ Yes	☐ No
Has the consumer provided permission to contact their healthcare professional?	☐ Yes	☐ No

If yes, please provide healthcare professional contact details:		
Name:	Type:	Telephone:
Address:		Email:

2. Patient Details			
Date of birth (Day/Month/Year)	Age Yrs/mo.	Height (cm)	Weight (kg)

3. Suspect Product Details

	Name	Strength	Dose	Route	Indication	Treatment Start date (day/month/year)	Treatment end date (day/month/year)	Lot	Exp. date
1.									
2.									
3.									

4. Peripheral Neuropathy Assessment

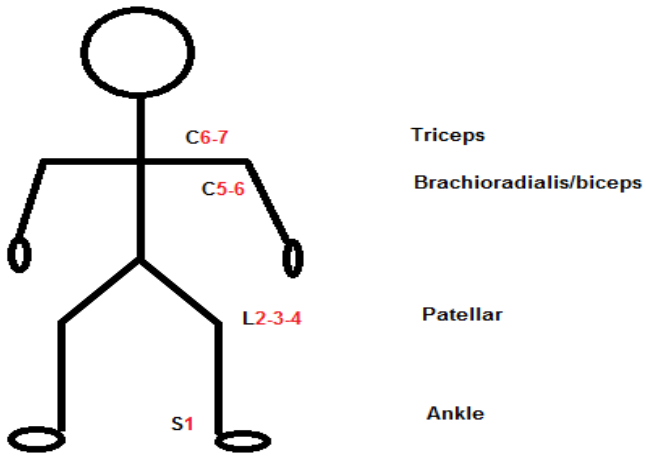
Symptoms

☐ Loss of sensation	☐ Tingling
☐ Lancination	☐ Muscle weakness
☐ Lack of coordination	☐ Numbness
☐ Pain	☐ Burning sensation

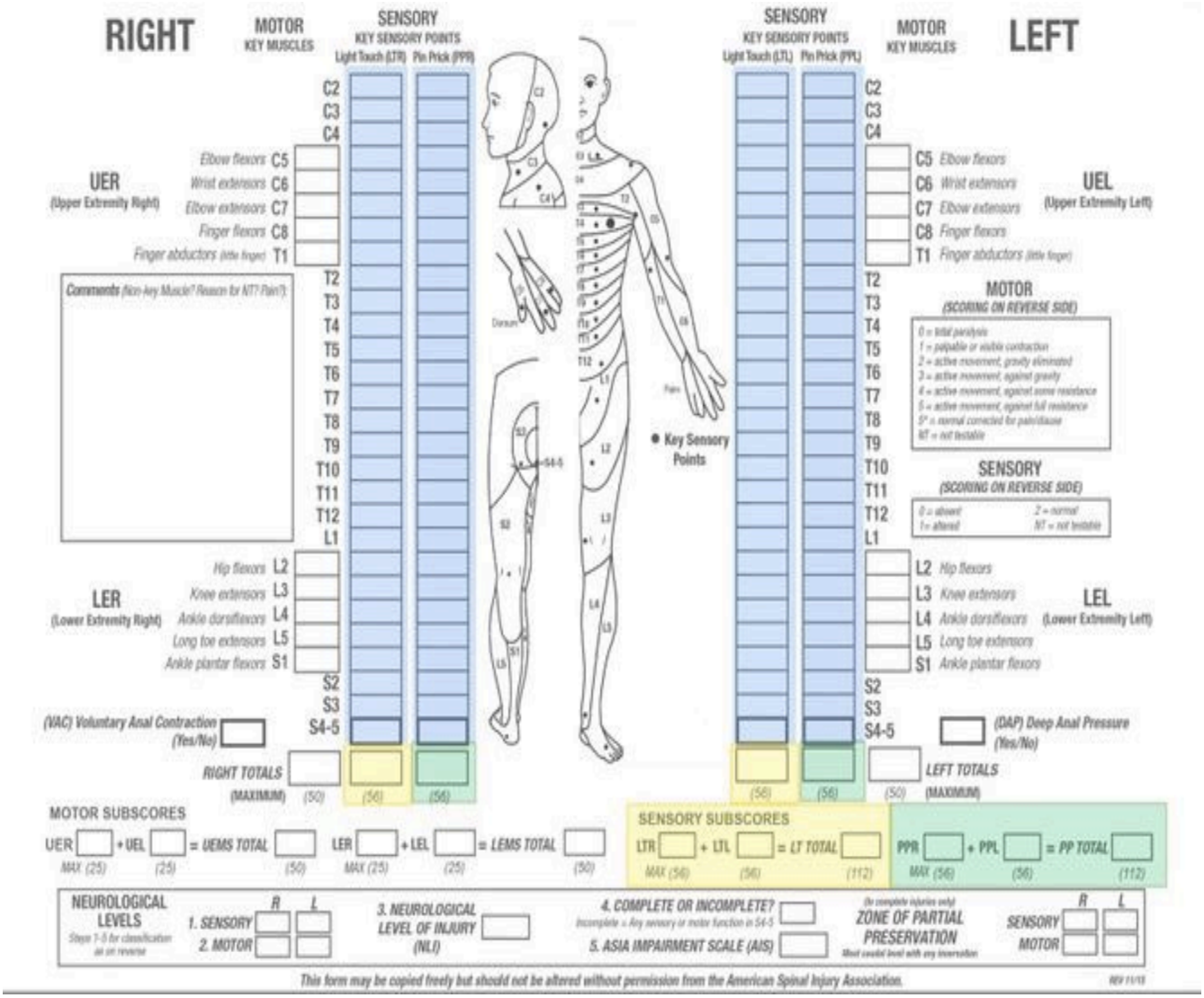
Other relevant symptoms

EXAMINATION of NERVOUS SYSTEM

DEEP TENDON REFLEXES	Right	Left
Biceps		
Triceps		
Brachioradialis		
Knee Jerk		
Ankle Jerk		
OTHER REFLEXES	**Right**	**Left**
Plantar Response		
Superficial Reflexes		
Cranial Nerves		



SENSORY EXAMINATION



5. Test Results			
	Date (day/month/year)	**Results**	**Normal Range**
Nerve conduction studies			
Other relevant test details:			

6. Medical History	
Patient's concomitant conditions, relevant medical history, known risk factors, relevant tests, and laboratory data.	
☐ Viral illness	☐ Diabetes
☐ Autoimmune disease	☐ Kidney disorders
☐ Liver disorders	☐ Vascular and blood disorders
☐ Stroke	☐ Seizure
☐ Nerve injury	☐ Toxic exposure
☐ Anaesthesia use/Surgery	☐ Drug abuse
☐ Injury/ Trauma	☐ Alcohol use: Glass/day
Other relevant medical history:	
Risk Factors	

7. Treatment
Treatment provided for the Peripheral Neuropathy:

8. Details of Other Adverse Events					
Adverse Event	Start Date (day/month/year)	Stop Date (day/month/year)	Hospitalization	Outcome	Event Causality
			☐ Yes ☐ No If yes, provide dates of hospitalization.	☐ Recovered / Resolved ☒ Recovered / Resolved with Sequelae ☐ Recovering /Resolving ☐ Not Recovered /Not Resolved ☐ Fatal	☐ Related ☐ Not Related ☐ Unknown

8. Details of Other Adverse Events					
Adverse Event	Start Date (day/month/year)	Stop Date (day/month/year)	Hospitalization	Outcome	Event Causality
				☐ Unknown	
			☐ Yes ☐ No If yes, provide dates of hospitalization.	☐ Recovered / Resolved ☐ Recovered / Resolved with Sequelae ☐ Recovering /Resolving ☐ Not Recovered /Not Resolved ☐ Fatal ☐ Unknown	☐ Related ☐ Not Related ☐ Unknown
			☐ Yes ☐ No If yes, provide dates of hospitalization.	☐ Recovered / Resolved ☐ Recovered / Resolved with Sequelae ☐ Recovering /Resolving ☐ Not Recovered /Not Resolved ☐ Fatal ☐ Unknown	☐ Related ☐ Not Related ☐ Unknown

9. Concomitant Drugs & Therapies

10. Completed By		
Name:	Signature:	Date (day/month/year):