Sağlık Bakanlığı
Türkiye İlaç ve Tıbbi Cihaz Kurumu

DRUG SIDE EFFECT REPORTING FORM

(This Form is for Patients and Patient Relatives)

Please* fill in all sections marked and try to provide as much information as possible!

1 Information about the person experiencing the side effect:

First name, last name or initials: **Female** ☐ **Male** ☐

*** Age or date of birth:** **Height:** **Weight:**

Other information (medical history of the patient, does the patient have diseases such as diabetes, high blood pressure, allergies, is the patient pregnant, if pregnant, information on the date of the last menstrual period, etc.):

2 Information about side effects:

***Describe the side effect experienced and how it occurred** (if this field is not sufficient, you can add a page to the form)_____
_____
_____
_____
_____
_____

When did it start? (if the exact date is unknown, you can write how long after the medication was started the side effect occurred):

*** How did the side effect affect the patient's life?** (Please check the box of the appropriate option)

☐ Slightly ☐ Disturbing, but did not affect daily life ☐ Affected daily life
☐ Hospitalization caused ☐ Cause permanent disability ☐ Caused by a congenital defect
☐ It caused a very serious disease ☐ Resulted in death ☐ Other _____

*** How is the person who experienced the side effect doing now?**

☐ Side effect completely resolved/recovered ☐ Recovering ☐ Symptoms persist/not recovered
☐ Disease aggravated ☐ Death ☐ Other _____

Can you provide more information? For example, did the patient use other medicines to treat the side effect? Did he/she stop taking the medication because of the side effect?

* Make sure you fill in all the marked sections.

Please turn the page ⇨

3 Information about the medicine suspected of causing the side effect:

Give us about the medication you suspect is causing the side effect.

***Name of Medicine:**

Dosage (e.g. 100 mg tablet, 3 times daily):

Reason for using the drug:

Start date: End date:

Medication discontinued due to side effects? ☐ Yes ☐ No

Are there any other medicines used at the same time? If yes, please provide information about these medicines as well. You can add a page if you want to provide information for more than one medication. If there are any herbal products or alternative therapies used, please also provide details about them.

Name of the other medicine:

Dosage (e.g. 100 mg tablet, 3 times daily)**:**

Reason for using the drug:

Start date: End date:

Do you think this medicine could also cause the side effect you reported (please check the appropriate box) ☐ Yes ☐ No ☐ Maybe

Was medication discontinued due to side effects? ☐ Yes ☐ No

4 Information about the person reporting the side effect:

It is important for us that you provide your contact details to provide additional information if needed!

* Name Surname:

Phone : e-mail:

* Address:

Your doctor's name and surname, address or institution (optional):

Do you agree to us contacting your doctor if we need more detailed medical information?

Yes ☐ No ☐

Thank you for filling out the form. You can send the form to our center by fax, e-mail or mail.
Address:Turkish Medicines and Medical Devices Agency Söğütözü Mahallesi 2176. Street No:5 Floor:8
Faks: 0 312 218 35 99 e-mail: tufam@titck.gov.tr
For your questions and notifications, you can reach TUFAM via our toll-free line at 0 800 314 00 08.