The FDA Safety Information and Adverse Event Reporting Program

A. PATIENT INFORMATION
1. Patient Identifier
   In confidence
2. Age at Time of Event: _____________________
3. Sex
   Female
   Male
4. Weight
   lbs
   kgs

B. ADVERSE EVENT OR PRODUCT PROBLEM
1. □ Adverse Event and/or □ Product Problem (e.g., defects/malfunctions)
2. Outcomes Attributed to Adverse Event
   □ Death: _____________________ (mo/day/yr)
   □ Life-threatening
   □ Hospitalization - initial or prolonged
   □ Other: _____________________
3. Date of Event (mo/day/year)
4. Date of This Report (mo/day/year)
5. Describe Event or Problem

C. SUSPECT MEDICATION(S)
1. Name (Give labeled strength & mfr/lbl, if known)
   #1
   #2
2. Dose, Frequency & Route Used
   #1
   #2
3. Therapy Dates (if unknown, give duration) from/to (or best estimate)
   #1
   #2
4. Diagnosis for Use (Indication)
   #1
   #2
5. Event Abated After Use Stopped or Dose Reduced?
   □ Yes □ No □ Doesn’t Apply
   #1
   #2
6. Lot # (if known)
   #1
   #2
7. Exp. Date (if known)
   #1
   #2
8. Event Reappeared After Reintroduction?
   □ Yes □ No □ Doesn’t Apply
   #1
   #2
9. NDC# (For product problems only)
   -
   -
10. Concomitant Medical Products and Therapy Dates (Exclude treatment of event)

D. SUSPECT MEDICAL DEVICE
1. Brand Name
2. Type of Device
3. Manufacturer Name, City and State
4. Model #
5. Operator of Device
   □ Health Professional
   □ Lay User/Patient
   □ Other:
   
6. If Implanted, Give Date (mo/day/yr)
7. If Explanted, Give Date (mo/day/yr)
8. Is this a Single-use Device that was Reprocessed and Reused on a Patient?
   □ Yes □ No
9. If Yes to Item No. 8, Enter Name and Address of Reprocessor
10. Device Available for Evaluation? (Do not send to FDA)
    □ Yes □ No □ Returned to Manufacturer on: _____________________ (mo/day/yr)
11. Concomitant Medical Products and Therapy Dates (Exclude treatment of event)

E. REPORTER (See confidentiality section on back)
1. Name and Address
2. Phone #
3. Occupation
4. Also Reported to:
   □ Manufacturer
   □ User Facility
   □ Distributor/Importer
5. If you do NOT want your identity disclosed to the manufacturer, place an “X” in this box: □
ADVICE ABOUT VOLUNTARY REPORTING

Report adverse experiences with:
- Medications (drugs or biologics)
- Medical devices (including in-vitro diagnostics)
- Special nutritional products (dietary supplements, medical foods, infant formulas)
- Cosmetics
- Medication errors

Report product problems - quality, performance or safety concerns such as:
- Suspected counterfeit product
- Suspected contamination
- Questionable stability
- Defective components
- Poor packaging or labeling
- Therapeutic failures

Report SERIOUS adverse events. An event is serious when the patient outcome is:
- Death
- Life-threatening (real risk of dying)
- Hospitalization (initial or prolonged)
- Disability (significant, persistent or permanent)
- Congenital anomaly
- Required intervention to prevent permanent impairment or damage

Report even if:
- You’re not certain the product caused the event
- You don’t have all the details

How to report:
- Just fill in the sections that apply to your report
- Use section C for all products except medical devices
- Attach additional blank pages if needed
- Use a separate form for each patient
- Report either to FDA or the manufacturer (or both)

Confidentiality: The patient’s identity is held in strict confidence by FDA and protected to the fullest extent of the law. FDA will not disclose the reporter’s identity in response to a request from the public, pursuant to the Freedom of Information Act. The reporter’s identity, including the identity of a self-reporter, may be shared with the manufacturer unless requested otherwise.

If your report involves a serious adverse event with a device and it occurred in a facility outside a doctor’s office, that facility may be legally required to report to FDA and/or the manufacturer. Please notify the person in that facility who would handle such reporting.

Important numbers:
- 1-800-FDA-0178 -- To FAX report
- 1-800-FDA-1088 -- To report by phone or for more information
- 1-800-822-7967 -- For a VAERS form for vaccines

To Report via the Internet:
http://www.fda.gov/medwatch/report.htm

The public reporting burden for this collection of information has been estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to:

Department of Health and Human Services
Food and Drug Administration
MedWatch; HFD-410
5600 Fishers Lane
Rockville, MD 20857

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Food and Drug Administration

Please Use Address Provided Below -- Fold in Thirds, Tape and Mail

DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service
Food and Drug Administration
Rockville, MD 20857

Official Business
Penalty for Private Use $300

BUSINESS REPLY MAIL
FIRST CLASS MAIL PERMIT NO. 946 ROCKVILLE MD
POSTAGE WILL BE PAID BY FOOD AND DRUG ADMINISTRATION

MEDWATCH
The FDA Safety Information and Adverse Event Reporting Program
Food and Drug Administration
5600 Fishers Lane
Rockville, MD 20852-9787