(نموذج رقم 2) (Form No. 2)

# CIOMS FORM (SUSAR REPORT)

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| SUSPECT ADVERSE REACTION REPORT |  | | | | | | | | | | | | | | |
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**I. REACTION INFORMATION**

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| 1. PATIENT INITIALS  (first, last) | 1a. COUNTRY | 2. DATE OF BIRTH | | | 2a. AGE  Years | 3. SEX | 4–6 REACTION ONSET | | | 8–12 CHECK ALL APPROPRIATE TO ADVERSE REACTION |
| Day | Month | Year |  | Day | Month | Year |
| 7 + 13 DESCRIBE REACTION(S) (including relevant tests/lab data) | | | | | | | | | | PATIENT DEATH  INVOLVED OR PROLONGED INPATIENT HOSPITALIATION  INVOLVED PERSISTENT OR SIGNIFICANT DISABILITY OR INCAPACITY  THREAT TO LIFE |

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| 14. SUSPECT DRUG(S) (include generic name) | | 20. DID REACTION ABATE AFTER STOPPING DRUG? |
|  | | YES  NO  NA |
| 15. DAILY DOSE(S) | 16. ROUTE(S) OF ADMINISTRATION | 21. DID REACTION REAPPEAR AFTER REINTRO- DUCTION? |
| 17. INDICATION(S) FOR USE | | YES  NO  NA |
| 18. THERAPY DATES (from/to) | 19. THERAPY DURATION | |

**II. SUSPECT DRUG(S) INFORMATION**

**III. CONCOMITANT DRUG(S) AND HISTORY**

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| 22. CONCOMITANT DRUG(S) AND DATES OF ADMINISTRATION (exclude drugs used to treat reaction) |
| 23. OTHER RELEVANT HISTORY (e.g., diagnostics, allergies, or pregnancy with last month of period, etc.) |

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| 24a. NAME AND ADDRESS OF MANUFACTURER | |  |
|  | 24b. MFR CONTROL NO. |
| 24c. DATE RECEIVED BY MANUFACTURER | 24d. REPORT SOURCE   STUDY  LITERATURE   HEALTH PROFESSIONAL |
| DATE OF THIS REPORT | 25a. REPORT TYPE   INITIAL  FOLLOW-UP |  |

**IV. MANUFACTURER INFORMATION**