BIOCON BIOLOGICS LIMITED

PHARMACOVIGILANCE DEPARTMENT

Biocon Biologics™
Transforming Healthcare. Transforming Lives.

Reporter's Information

Reporter Type : ☐ Health Care Professional ☐ Patient ☐ Other : _____

Name / Initial of the Reporter: _____ Country : _____

Email : _____ Mobile number : _____

Patient Information:

Name/Initial : _____ Age (Years) : _____ DOB : _____ Gender : ☐ M ☐ F

Suspect Drug Information

Brand Name: _____ Generic Name : _____ Batch No/Lot No: _____

Country Where Medicinal Product Was Purchased : _____

Duration of use From : _____ To : _____

OR

If exact dates not known approx duration of use: _____ .
(Like minutes,hours,days,months,years, etc..)

Event Information

Event Type : ☐ Adverse Event / Side effect ☐ Product Problem ☐ Others

Event Onset Date : _____ Country Of Occurrence : _____

Please describe the adverse event/product complaint (if you are a health care professional include event term/diagnosis of the adverse event/side effect)*

What is the outcome of the event condition

☐ Recovered/Resolved ☐ Not recovered/Not resolved ☐ Recovering/Resolving ☐ Recovered/Resolved with sequelae

☐ Unknown ☐ Death/Fatal

Do you consider the adverse event/side effect as serious : ☐ Yes ☐ No

Email us at : **DrugSafety@biocon.com**