WAVE PHARMACEUTICALS LIMITED

Adverse Event Reporting Form

A. Patient information

1. Patient Initials ☐☐☐
2. Age at time of event: _____ or Date of Birth: ___/___/_____ dd / mm / yyyy
3. Gender: ☐ M ☐ F
4. Weight: _____Kg.
5. Country: _____

B. Adverse Event

6. Date when event started (dd/mm/yyyy): ___/___/_____
7. Date of recovery (dd/mm/yyyy): ___/___/_____
8. Describe event:
9. Relationship of event to the suspected medication
   ☐ Related ☐ Not related

13. Relevant tests/ laboratory data, including dates

14. Other relevant history, including pre-existing medical conditions (e.g., allergies, race, pregnancy, smoking alcohol use, hepatic/renal dysfunction, etc.)

15. Seriousness of the event : Is the event Serious ☐ or Non serious ☐
    If Serious, then choose the criteria
    - ☐ Death (dd/mm/yyyy) ___/___/_____
    - ☐ Life threatening
    - ☐ requires inpatient hospitalization or prolongation of hospitalization
    - ☐ Results in persistent or significant disability/incapacity
    - ☐ congenital anomaly/ Birth defect
    - ☐ other medically important condition

16. Outcomes
    ☐ Fatal ☐ Continuing ☐ Recovering ☐ Recovered ☐ Unknown
    ☐ Other (specify) _____

C. Suspected medication(s)

Sr. No.	10. Name (brand and / or generic name)	Manufacturer (If known)	Batch No. / Lot No. (If known)	Exp. Date (If known)	Dose used	Route used	Frequency	Therapy dates (if unknown, give duration)		Reason for Use or prescribed for
								Date started	Date stopped	
i										
ii										
iii										
iv										

11. **Action taken with respect to Suspect Drug**

- ☐ None
- ☐ Dose reduction — Date of dose reduction : ___/___/___ (dd/mm/yyyy)
- ☐ Drug temporarily discontinued — Date stopped : ___/___/_____ (dd/mm/yyyy) — Date re-started : ___/___/___ (dd/mm/yyyy)
- ☐ Drug permanently discontinued — Date stopped : ___/___/_____ (dd/mm/yyyy)
- ☐ Dose increased — Date of dose increased : ___/___/_____ (dd/mm/yyyy)

12. Concomitant medical products and therapy dates including self medication and herbal remedies (exclude those used to treat event

D. Reporter

☐ Healthcare Professional ☐ Consumer ☐ Other

17. Name and Address: _____

Pin code: _____ E-mail: _____

Cell No./Tel. No. with STD Code: _____

Specialty: _____ Signature:

18. Occupation: _____

19. Date of this report (dd/mm/yyyy) ___/___/_____