



PHARMACOVIGILANCE AND CLINICAL TRIALS DIVISION

Spontaneous Adverse Drug Reaction (ADR) Report Form					
Identities of Reporter, Patient and Institute will remain confidential					
MCAZ Reference Number (MCAZ use only)					
Patient Details					
Clinic/Hospital Name:		Clinic/Hospital Number			
Patient Initials:		VCT/OI/TB Number			
Date of Birth:		Weight (Kg)	Sex:		
Age:		Height (meters)			
Adverse Reaction					
Date of Onset:					
Duration:	Less than one hour	Hours	Days	Weeks	Months
Description of ADR:					
Serious: Yes ☐ No ☐	Reason for Seriousness	☐ Death		☐ Life-threatening	
		☐ Hospitalization/prolonged		☐ Disabling	
		☐ Congenital-anomaly		☐ Other medically important condition	
Current Medication (including OTC and herbals)					
Generic/Brand Name	Batch No.	Dose and frequency	Date started	Date stopped	Tick Suspected medicine(s)
Relevant Past Drug Therapy					
Generic/Brand name	Batch No.	Dose and frequency	Date started	Date stopped	Tick Suspected medicine(s)
Relevant Medical History					
Laboratory tests results:					
Action taken: ☐ Drug withdrawn ☐ Dose increased ☐ Unknown ☐ Dose reduced ☐ Dose not changed ☐ Not applicable		Outcome of ADR: ☐ Recovered/resolved ☐ Recovering/resolving ☐ Recovered/resolved with sequelae ☐ Not recovered/not resolved ☐ Fatal ☐ Unknown			
Reported by					
Forename(s) & Surname:					
Designation:					
Email Address:					
Phone Number					
Name & Address of Institution					
Send to: The Director-General, Medicines Control Authority of Zimbabwe, 106 Baines Avenue, P O Box 10559, Harare					
Tel: +263-4-708255 or 792165, E-mail: mcas@mcas.co.zw , website: www.mcas.co.zw , online: www.e-pv.mcas.co.zw					

NB. This form may be completed for any ADR related to medicines or medical devices.

Please attach any other additional information, including an anonymized picture of the ADR (with the patient's consent)