



PHARMACOVIGILANCE AND CLINICAL TRIALS DIVISION

MEDICINES SAFETY AND EFFICACY MONITORING FORM FOR COVID-19 TREATMENT

This form should be completed for medicines obtained under Section 75 of the Medicines and Allied Substances Control Act [Chapter 15:03] in order to assess the medicine's treatment outcomes and safety in the treatment of COVID-19 disease or any other medicines deemed necessary by the Authority. Identities of reporter, patient and institute will remain CONFIDENTIAL. This form is to be completed for EACH patient who is prescribed/or dispensed a medicine for the treatment COVID-19 disease. Adverse Drug Reactions experienced by the patient should be reported by completing (SECTION D) below or submitted electronically on <https://e-pv.mcaz.co.zw>.

SECTION A

Patient details

Patient Initials:	Date of Birth/ Age:
Weight <i>if known</i> : Height <i>if known</i> :	Gender: ☐ Male ☐ Female

SECTION B

COVID-19 Diagnosis

Date of diagnosis: / /			
Diagnosis of COVID-19: ☐ Positive PCR ☐ Positive Antigen ☐ Positive Antibody ☐ Possible (Clinical signs and symptoms/ pending PCR)			
COVID-19 disease severity: ☐ Mild ☐ Moderate ☐ Severe			
SPO2 (on ambient air)	Resp rate	Pulse	Temperarture
Comorbid conditions that negatively affect prognosis and survival?			
☐ None	☐ Diabetes Mellitus	☐ Cardiovascular disease	
☐ Malignancy	☐ Chronic lung disease	☐ Pregnancy	
☐ Unknown	☐ Hypertension	☐ HIV	
☐ Asthma			
☐ Other:			

SECTION C

Details of COVID-19 Medicine of interest

Generic name	Brand name	Batch number	Dose	Route and frequency		Date started	Date stopped

Concomitant (other) medicines taken, including herbal medicines

Generic name	Brand name	Batch number	Dose	Route and frequency		Indication	Date started	Date stopped

SECTION D

Outcome

Date of follow-up: / /			
Was the medicine effective? ☐ Yes ☐ No			
Outcome			
☐ Recovered	☐ No change	☐ Condition worsened	
☐ Death	☐ Other (<i>explain</i>):		
Test results post treatment (if done)			
Date of test: / /			
☐ Negative PCR test	☐ Negative antibody test	☐ Positive PCR test	
☐ Negative Antigen test	☐ Positive Antigen test	☐ Positive Antibody test	
☐ Other (<i>explain</i>):			
Symptoms Observed post treatment			
Date of observation: / /			
☐ None	☐ Body ache	☐ Shortness of breath	☐ Diarrhoea
☐ Tiredness	☐ Headache	☐ Nasal congestion	☐ Sore throat
☐ Cough	☐ Runny nose	☐ Loss of smell	☐ Fever
☐ Other:			
COVID-19 disease severity post treatment			
☐ Mild	☐ Moderate	☐ Severe	
SPO2 (on ambient air)	Resp rate	Pulse	Temperature

SECTION E**Safety evaluation****Adverse events/Side effects**

Did the patient experience any side effects/adverse events while taking this medicine? ☐ Yes
☐ No

If yes proceed to complete the attached ADR reporting form, alternatively adverse drug reactions experienced by the patient may be submitted electronically on <https://e-pv.mcaz.co.zw>

Reporter details

Forename(s): Surname:

Institution:

Designation:

Email: Mobile/Telephone number: