

**CENTRAL STATE HOSPITAL
ADVERSE DRUG REACTION/EXPERIENCES REPORT FORM**

Reaction Discovery - Date: _____ Time: _____ AM PM

Reaction: EPS Tachycardia Diarrhea Seizure
 Hives/Urticaria Bradycardia Sedation Anaphylaxis
 Rash Wheezing/SOB Mania/"Hyper" Shock
 Hypotension Fever Hemolysis Death
 Hypertension Nausea/Vomiting Liver damage Other (describe below)

Describe Reaction: _____

Name of suspected medication: _____ Dose/Route: _____

Was the client treated for the reaction? YES NO

If yes, describe the treatment: _____

Was the drug discontinued? YES NO

If no, explain: _____

Outcome of Treatment: Resolved Unresolved

If unresolved, explain: _____

Drug/Drug Interaction Suspected? YES NO

Name(s) of Drug(s) Suspected: _____

Food/Drug Interaction Suspected? YES NO

Name(s) of Food/Drug(s) Suspected: _____

Report Completed By: _____ Date: _____ Time: _____ AM PM

When the above section is complete, send this form to the CMO's office.

<i>To be completed by the CMO:</i>			
<input type="checkbox"/> Level I	No change in treatment with the suspected drug.	<input type="checkbox"/> Level IV	ADR required transfer of client to an acute care setting.
<input type="checkbox"/> Level II	Drug held, discontinued, or changed, but no antidote or additional treatment needed.	<input type="checkbox"/> Level V	ADR caused permanent harm to the client.
<input type="checkbox"/> Level III	Drug held, discontinued, or changed, AND antidote or other treatment was needed.	<input type="checkbox"/> Level VI	ADR directly or indirectly led to the client's death.

A severe ADR is Level IV or greater.

Recommendations/Actions: Report to FDA Refer for Review/Peer Review
 Report to Manufacturer No Further Action

Comments: _____

STAMP PLATE

Signature of CMO/Designee

Date/Time