ADR Spontaneous Report Form short version

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Local case ID:	**Date of receipt of information:**
Initial report ☐ **Follow-up report** ☐	**Follow-up information requested:** Yes ☐ No ☐

Give information on the patient who has experienced the Adverse Event.

Initials	**Gender** male ☐ female ☐	**Age** [years]	

Which Adverse Event(s) has the patient experienced?

1.	**2.**	**3.**	**4.**
Date:	**Date:**	**Date:**	**Date:**

Was the patient hospitalized? Yes ☐ No ☐ **Did the patient die?** Yes ☐ No ☐

Describe details of the Adverse Event(s).

For contrast agents, please describe the procedure. (e.g. MRI, CT)

Which Bayer drug(s) were involved?

Trade Name/ Generic Name	**Formu-lation**	**Total daily dose**	**Dose regimen**	**Route of applica-tion**	**Lot number**	**Date from-to or duration**	**Indication for use**
LNG IUS							

Who has reported the Adverse Event(s)?

Name			
Address			
Phone/Fax/ E-Mail			
Physician ☐	Consumer ☐	Other ☐	specify:

IF MORE DETAILED INFORMATION ARE AVAILABLE FILL IN THE FULL VERSION OF THE SPONTANEOUS REPORT FORM , PLEASE.