Adverse Drug Reaction Collection Form

Fill out mandatory items (*) and complete form with additional information, if possible.

Send filled form to Drug Safety Allergopharma:

E-mail: pharmacovigilance@allergopharma.com

Phone: +49 40-72765712, Fax: +49 40-72765252

Allergopharma GmbH & Co. KG
Drug Safety
Hermann-Körner-Str. 52
21462 Reinbek · Germany

1. Reporter Details

Reporter is (*): ☐ Patient ☐ Relative

Contact details (optional):

2. Patient Details

Initials: _____ (Last name First name)

Date of birth: _____ (DD . MM . YYYY)

Age: _____ years

Sex (*): ☐ male ☐ female

3. Suspected Product Details

Product name (*):

Start date: _____ (DD . MM . YYYY)

End date: _____ (DD . MM . YYYY)

Allergen composition:

Date of last injection: _____ (DD . MM . YYYY)

Batch No:

The reaction was observed at a dose of:

_____ ml Strength: _____ (1,2,3 or A/B)

4. Adverse Drug Reaction Details

Date of reaction(s): _____ (DD . MM . YYYY)

Duration of reaction(s): _____ (min./hrs./days)

The reaction(s) appeared _____ (min./hrs./days) after indication.

Description of reaction: (*):

Date of report: _____ (DD . MM . YYYY)