Instructions | Erase | Print | Save as

Santé et Services sociaux Québec

DT9309

User's last name

First name

File Number

Year Month Day Sex

Date of birth ☐ M ☐ F

Health Insurance Number Year Month

Expiry date

NEW ALLERGIC DRUG REACTION REPORTING FORM

Click on underlined words for instructions.

SUSPECTED DRUGS (List in order of probability)

Drug name	Start of treatment Year Month Day	End of treatment Year Month Day
1.		
2.		
3.		

Key Clinical Manifestations

Started (Year Month Day) | Ended (Year Month Day) | ☐ Ongoing

Interval between dose and reaction (e.g., minutes/hours/days)

Cutaneous manifestations (Check all that apply)	Other manifestations (Check all that apply)	Additional information (e.g., location of lesions, severity, etc.)
☐ Mucous membrane involvement	☐ Gastrointestinal	
☐ Bullae/pustules	☐ Fever > 38 °C	
☐ Desquamation	☐ Hematologic	
☐ Maculopapular rash	☐ Hepatic	
☐ Edema	☐ Hypotension	
☐ Palpable purpura	☐ Renal	
☐ Urticaria	☐ Respiratory	

Manifestations disappeared after withdrawal of drug ☐ Yes ☐ No ☐ Not known

Hospitalization required ☐ Yes ☐ No ☐ Not known

If yes, please specify (e.g., emergency department, intensive care unit):

Treatment for key clinical manifestations

☐ None ☐ Systemic corticosteroid ☐ Epinephrine

☐ Antihistamine ☐ Topical corticosteroid ☐ Other:

☐ Response to treatment: ☐ Yes ☐ No (Please specify):

Current allergy status

☐ Confirmed allergy:

☐ Suspected allergy:

Referral for allergy consultation

☐ Yes Date (Year Month Day)

☐ No

Conclusions: Please specify the severity of the observed allergic reaction

☐ Immediate allergic reaction (IgE-mediated, or type I)

Severity (Please specify):

☐ Delayed allergic reaction (type II, III or IV)

Severity (Please specify):

☐ Not known

Signature		License No.	Date	Year Month Day