



DT9309

NEW ALLERGIC DRUG REACTION REPORTING FORM

User's last name					
First name					
File Number					
Year		Month		Day	
Date of birth				Sex	
				<input type="checkbox"/> M <input type="checkbox"/> F	
Health Insurance Number				Year	
				Month	
				Expiry date	

Click on underlined words for instructions.

SUSPECTED DRUGS (List in order of probability)						
Drug name			Start of treatment		End of treatment	
			Year	Month	Day	Year
1.						
2.						
3.						
Key Clinical Manifestations						
Started		Year	Month	Day	Ended	
<input type="checkbox"/> Ongoing						
Interval between dose and reaction (e.g., minutes/hours/days)						
Cutaneous manifestations		Other manifestations		Additional information		
(Check all that apply)		(Check all that apply)		(e.g., location of lesions, severity, etc.)		
<input type="checkbox"/> Mucous membrane involvement <input type="checkbox"/> Bullae/pustules <input type="checkbox"/> Desquamation <input type="checkbox"/> Maculopapular rash <input type="checkbox"/> Edema <input type="checkbox"/> Palpable purpura <input type="checkbox"/> Urticaria		<input type="checkbox"/> Gastrointestinal <input type="checkbox"/> Fever > 38 °C <input type="checkbox"/> Hematologic <input type="checkbox"/> Hepatic <input type="checkbox"/> Hypotension <input type="checkbox"/> Renal <input type="checkbox"/> Respiratory				
Manifestations disappeared after withdrawal of drug				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known		
Hospitalization required				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known		
If yes, please specify (e.g., emergency department, intensive care unit):						
Treatment for key clinical manifestations						
<input type="checkbox"/> None		<input type="checkbox"/> Systemic corticosteroid		<input type="checkbox"/> Epinephrine		
<input type="checkbox"/> Antihistamine		<input type="checkbox"/> Topical corticosteroid		<input type="checkbox"/> Other:		
<input type="checkbox"/> Response to treatment:		<input type="checkbox"/> Yes <input type="checkbox"/> No (Please specify):				
Current allergy status			Referral for allergy consultation			
<input type="checkbox"/> Confirmed allergy:			<input type="checkbox"/> Yes Date			
<input type="checkbox"/> Suspected allergy:			Year Month Day			
			<input type="checkbox"/> No			
Conclusions: Please specify the severity of the observed allergic reaction						
<input type="checkbox"/> Immediate allergic reaction (IgE-mediated, or type I)						
Severity (Please specify):						
<input type="checkbox"/> Delayed allergic reaction (type II, III or IV)						
Severity (Please specify):						
<input type="checkbox"/> Not known						
Signature		License No.		Date		
				Year Month Day		