

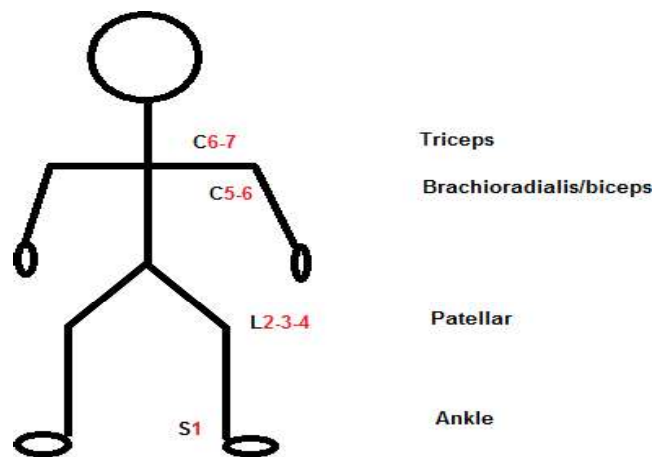
1. Reporter Details		☐ Initial	☐ Follow-up
Reporter Name:		E-mail:	
Contact address:		Telephone number:	
		Fax number:	
Type:	☐ Physician (Specialty): _____	☐ Consumer or other non healthcare professional	
	☐ Pharmacist	☐ Other (Specify) _____	
If reporter is a consumer, have they informed their physician of the exposure?		☐ Yes	☐ No
Has the consumer provided permission to contact their healthcare professional?		☐ Yes	☐ No
If yes, please provide healthcare professional contact details:			
Name:		Type:	Telephone:
Address:		Email:	

2. Patient Details			
Date of birth (Day/Month/Year)	Age Yrs/mo.	Height (cm)	Weight (kg)

3. Suspect Product Details									
	Name	Strength	Dos e	Route	Indication	Treatment Start date (day/month/year)	Treatment end date (day/month/year)	Lot	Exp. date
1.									
2.									
3.									

4. Peripheral Neuropathy Assessment	
Symptoms	
☐ Loss of sensation	☐ Tingling
☐ Lancination	☐ Muscle weakness
☐ Lack of coordination	☐ Numbness
☐ Pain	☐ Burning sensation
Other relevant symptoms	
EXAMINATION of NERVOUS SYSTEM	

DEEP REFLEXES	TENDON	Right	Left
Biceps			
Triceps			
Brachioradialis			
Knee Jerk			
Ankle Jerk			
OTHER REFLEXES		Right	Left
Plantar Response			
Superficial Reflexes			
Cranial Nerves			



SENSORY EXAMINATION

RIGHT **MOTOR KEY MUSCLES** **SENSORY KEY SENSORY POINTS** **SENSORY KEY SENSORY POINTS** **MOTOR KEY MUSCLES** **LEFT**

UER (Upper Extremity Right) **UEL** (Upper Extremity Left)

LER (Lower Extremity Right) **LEL** (Lower Extremity Left)

(NAC) Voluntary Anal Contraction (Yes/No) **(DAP) Deep Anal Pressure** (Yes/No)

RIGHT TOTALS (MAXIMUM) **LEFT TOTALS** (MAXIMUM)

MOTOR SUBSCORES **SENSORY SUBSCORES**

1. SENSORY **2. MOTOR** **3. NEUROLOGICAL LEVEL OF INJURY (NLI)** **4. COMPLETE OR INCOMPLETE?** **5. ASIA IMPAIRMENT SCALE (AIS)**

NEUROLOGICAL LEVELS **ZONE OF PARTIAL PRESERVATION**

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5. Test Results

	Date (day/month/year)	Results	Normal Range
Nerve conduction studies			
Other relevant test details:			

6. Medical History

Patient's concomitant conditions, relevant medical history, known risk factors, relevant tests, and laboratory data.

☐ Viral illness	☐ Diabetes
☐ Autoimmune disease	☐ Kidney disorders
☐ Liver disorders	☐ Vascular and blood disorders
☐ Stroke	☐ Seizure
☐ Nerve injury	☐ Toxic exposure
☐ Anaesthesia use/Surgery	☐ Drug abuse
☐ Injury/ Trauma	☐ Alcohol use: Glass/day

Other relevant medical history:

Risk Factors

7. Treatment

Treatment provided for the Peripheral Neuropathy:

8. Details of Adverse Events

Adverse Event	Start Date (day/month/year)	Stop Date (day/month/year)	Hospitalization	Outcome	Event Causality
			☐ Yes ☐ No If yes, provide dates of hospitalization.	☐ Recovered / Resolved ☐ Recovered / Resolved with Sequelae ☐ Recovering /Resolving ☐ Not Recovered /Not Resolved ☐ Fatal	☐ Related ☐ Not Related ☐ Unknown

8. Details of Other Adverse Events

Adverse Event	Start Date (day/month/year)	Stop Date (day/month/year)	Hospitalization	Outcome	Event Causality
				☐ Unknown	
			☐ Yes ☐ No If yes, provide dates of hospitalization.	☐ Recovered / Resolved ☐ Recovered / Resolved with Sequelae ☐ Recovering /Resolving ☐ Not Recovered /Not Resolved ☐ Fatal ☐ Unknown	☐ Related ☐ Not Related ☐ Unknown
			☐ Yes ☐ No If yes, provide dates of hospitalization.	☐ Recovered / Resolved ☐ Recovered / Resolved with Sequelae ☐ Recovering /Resolving ☐ Not Recovered /Not Resolved ☐ Fatal ☐ Unknown	☐ Related ☐ Not Related ☐ Unknown

9. Concomitant Drugs & Therapies

Name	Dose	Indication	Treatment start date (day/month/year)	Treatment end date (day/month/year)

10. Completed By

Name:	Signature:	Date (day/month/year):
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