

Restricted

限閱文件

REPORT TO DEPARTMENT OF HEALTH ON CHINESE MEDICINE-RELATED ADVERSE EVENT
向衛生署呈報與中藥有關的不良反應事故

CENTRAL NOTIFICATION OFFICE, CENTRE FOR HEALTH PROTECTION 衛生防護中心中央呈報辦公室

Fax 傳真：2477 2770; Tel. 電話：2477 2772

PARTICULARS OF AFFECTED PERSON 受影響人士的資料

Name in English 英文姓名:	Name in Chinese 中文姓名:	Age/Sex 年齡/性別:	I.D. Card/Passport No. 身分證/護照號碼:
Address 地址:			Telephone Number 電話號碼:
Place of Work/ School Attended 工作地點/就讀學校:			Telephone Number 電話號碼:
Hospital(s) attended 就診醫院:			Hospital/A&E Number 醫院/急症室號碼:

Chinese medicine-related Adverse Event suspected/confirmed on ___/___/___.
在 ___/___/___ (日/月/年) 懷疑 / 證實與中藥有關的不良反應事故.

Please specify 請註明: _____

(Please attach supplementary form for reporting Chinese medicine-related adverse events)

(請夾附呈報與中藥有關的不良反應事故的補充表格)

Reported by

由 _____ 中醫師呈報 on _____ / _____ / _____
(Full Name in BLOCK Letters 正楷全名) (Date 日期: 日/月/年)

Telephone number 電話號碼: _____
(Signature 簽署)

Remarks 備註:

**Supplementary Form for Reporting
Chinese medicine-related Adverse Events**

From: _____ Tel no.: _____

To: Central Notification Office, Centre for Health Protection, Department of Health

Fax: 2477 2770 (Tel: 2477 2772)

Part I Clinical history of patient

Presenting symptoms with date of onset:

Relevant medical history:

Relevant drug history:

Investigation(s) done and results (please provide a copy of relevant laboratory results):

Treatment given and current condition:

Follow up plan:

Part II Details of Incriminated Chinese Medicine (CM)

Name of CM in English:	Name of CM in Chinese:
Active ingredients of the CM (if known):	
Supposed indication for use:	Any people with same exposure: Y/N If yes, please provide name(s) and tel. nos.:
Dosage, preparation method and duration of consumption (please <i>fax the prescription sheet</i> and details of preparation together with this form if available):	
Any remnants or raw herbs collected from the patient? Y/N (Please note that DH will analyse the contents of the remnants and raw herbs if available.)	
Laboratory tests done on the herbs (if any) and results (please provide a copy of relevant laboratory results):	
Is the CM prescribed by a listed / registered CM practitioner? Y / N Name and address of CM practitioner whom the patient consulted:	
Name of herbal shop (if not dispensed by CM practitioner):	Address of herbal shop: