Connecticut Department of Children and Families

SUSPECTED ADVERSE DRUG REACTION REPORTING FORM (FAX TO: 1-877-DCF-DRUG)

DCF-465B
12/12 (Rev.)

IF ADVERSE DRUG REACTION (ADR) TO A MEDICATION IS SUSPECTED, NOTIFY THE PRESCRIBING AND/OR ATTENDING PHYSICIAN IMMEDIATELY. COMPLETE SECTION BELOW AND FAX TO DCF CENTRALIZED MEDICATION CONSENT UNIT AT 1-877-DCF-DRUG OR E-MAIL TO GETMEDS@CT.GOV

SECTION I: To be completed by the individual discovering the suspected ADR

Client Name: _____ Date: _____

Location: _____ LINK# _____

Suspected Medication: _____ Dosage Regimen: _____

Date of 1st Dose _____ Time of 1st Dose _____ Date of Reaction _____ Time of Reaction _____

Reported by: _____ ☐ MD ☐ RN ☐ APRN ☐ RPH Other: _____

Responsible Physician Physician Notified?: ☐ Yes ☐ No

TYPE OF REACTION (check all that apply)

☐ Rash ☐ Diarrhea ☐ Nausea ☐ Fever ☐ Hypotension ☐ Vomiting ☐ GI Upset ☐ Abnormal lab

Describe:

☐ Blood dyscrasia (type): ☐ EPS (type) ☐ Vertigo ☐ Tachycardia ☐ Hypersalivation

Other:

SECTION II: To be completed by DCF Clinical Pharmacist. For significant ADR's check all that apply

☐ ADR was reason for hospital admission

☐ Medication was required to treat the ADR (Please list Medication:

☐ ADR resulted in temporary / permanent disability (Please Describe:

☐ ADR prolonged hospital stay

☐ Other treatments were needed to resolve the ADR (Please Describe:

☐ ADR was reported to the FDA

ADR was: ☐ Idiosyncratic ☐ Dose related (Please Explain):

Know drug allergies: Other current medication:

DCF Clinical Pharmacist: Date:

SECTION III: TDCF Psychotropic Medication Advisory Committee Review of Possible ADR

Agree the ADR was significant and probable / highly probable ☐ Yes ☐ No

Was there an indication for the use of the suspected drug? ☐ Yes ☐ No

Was the dose within the recommended range? ☐ Yes ☐ No

Were there any contraindications present? ☐ Yes ☐ No

Comments / recommendations:

Reviewed by: Date: