



DT9309

## NEW ALLERGIC DRUG REACTION REPORTING FORM

See instructions on how to use this form on reverse side.

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	

SUSPECTED DRUGS (List in order of probability)																	
Drug name			Start of treatment			End of treatment											
			Year	Month	Day	Year	Month	Day									
1.																	
2.																	
3.																	
Key Clinical Manifestations																	
Started			Year	Month	Day	Ended			Year	Month	Day	<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: _____						<input type="checkbox"/> No											
						Year		Month		Day							
Conclusions: Please specify the severity of the observed allergic reaction (see details on reverse side)																	
<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		

## General instructions

Any health professional (*e.g., physician, nurse or pharmacist*) who suspects an allergic reaction may use this form.

Do not use this form to report a predictable adverse drug reaction caused by a non-allergic intolerance or that is pseudoallergic in nature, or to report the allergy history provided by the user.

- Use only to report allergic reactions to drugs.
- Report all suspected allergic reactions that you observe.
- Sign and date the form at the bottom.

## Suspected Drugs

- You can report up to three suspected drugs with each form (if applicable), starting with the most probable drug and providing the treatment start and end dates.

## Key Clinical Manifestations

- Report only the clinical manifestations of allergic reactions that you cannot clearly link to one or more preexisting conditions, by checking all of the listed items that apply.
- Indicate the observed manifestations by checking one or more of the items listed and/or describe them in your own words in the space provided under “Additional Information”. Examples:
  - Type and location of edema (*e.g., lips, tongue, throat, face or generalized*);
  - Gastrointestinal problem (*e.g., vomiting or severe diarrhea*);
  - Hematologic disorder (*e.g., adenopathy, anemia, eosinophilia or lymphocytosis*);
  - Renal impairment (*e.g., proteinuria or an increase in the urea and/or creatinine level*);
  - Hepatic impairment (*e.g., an increase in transaminase levels*);
  - Respiratory impairment (*e.g., breathing difficulties, bronchospasm, dyspnea, dysphonia or stridor*).
- Indicate whether the observed clinical manifestations disappeared after withdrawal of the suspected drug or drugs, and if the user required hospitalization.

## Additional information

- Indicate, if appropriate, any medical history that could potentially influence the reported clinical manifestations, such as prior known drug allergies, a concomitant HIV and other viral infection (*e.g., Epstein-Barr virus*) and/or concomitant diseases (*e.g., cystic fibrosis or chronic urticaria*).

## Treatment for key clinical manifestations

- Indicate whether the reaction required treatment. If it did, indicate the treatment and the response to it.

## Current allergy status

- Indicate whether the allergy has been confirmed by a physician by means of valid, appropriate tests (skin or provocation test) or by the occurrence of convincing clinical manifestations (*e.g., anaphylactic shock, SJS/TEN or DRESS*).
- Indicate whether a health professional suspects an allergy after having observed clinical manifestations suggestive of an allergic reaction but which require further investigation.

## Referral for allergy consultation

- If more than one drug is suspected, it is highly recommended that user be referred to an allergy consultation.
- The consultation request should be accompanied by this duly completed form.
- Once the drug allergy has been confirmed by a physician with valid and appropriate tests, a new “Allergic Drug Reaction Reporting Form” should be duly completed in order to update the user’s medical record.

## Conclusions and severity of the observed allergic reaction

- Indicate whether the observed reaction was immediate (IgE-mediated) and non-severe (*e.g., isolated urticaria*), severe (*e.g., anaphylaxis without shock or intubation*) or very severe (*e.g., anaphylactic shock*).
- Indicate whether the observed reaction was delayed and non-severe (*e.g., isolated maculopapular eruption (rash)*), severe (*e.g., serum sickness, maculopapular eruption with desquamation, fever, joint pain or slight internal organ involvement*) or very severe (*e.g., hemolytic anemia, hepatic or renal involvement, SJS/TEN, DRESS or AGEP*).

## Once this form is completed

- Keep this form in the user’s medical record in accordance with the institution’s rules and, whenever possible, send a copy of the form to the other health professionals involved in the user’s care.
- Keep complete, up-to-date information on the user’s drug allergy status in his/her medical record and include this information in other documents, as specified in the institution’s rules.
- Take the necessary steps to clearly inform the user or legal guardian of the diagnosis, the type of reaction and the name of the drug (where appropriate) that caused it.

**Acronyms:** AGEP: Acute Generalised Exanthematous Pustulosis, DRESS: Drug Reaction with Eosinophilia and Systemic Symptoms, SJS: Stevens-Johnson syndrome, TEN: Toxic epidermal necrolysis.