



# ADVERSE EVENT REPORT

Date of this Report (dd/mm/yyyy)

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## PATIENT INFORMATION

Initials	Age	Date of Birth (dd/mm/yyyy)	Amgen Drug Name	Dose	Frequency	Route
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Male	Female	<input type="text"/>	Date of First Dose	<input type="text"/>	Date of Last Dose before Event	<input type="text"/>

## ADVERSE EVENT

Event Term	Event Start Date (dd/mm/yyyy) and Time (HH:MM; 24 hr)	
<input type="text"/>	<input type="text"/>	<input type="text"/>

Event Description

Diagnostic Tests

Treatment

The patient recovered from the event.	Yes	Date (dd/mm/yyyy)	<input type="text"/>	No	Unknown
The patient passed away because of the event.	Yes	Date (dd/mm/yyyy)	<input type="text"/>	No	Unknown
The event was life-threatening.	Yes	No	Unknown		
The event caused persistent or significant disability.	Yes	No	Unknown		
Hospitalization or prolongation of hospitalization was needed.	Yes	No	Unknown		
The event involved congenital anomaly or birth defect.	Yes	No	Unknown		
The event subsided after withdrawal of the drug.	Yes	No	Unknown		
The event reoccurred after restarting the drug.	Yes	No	Unknown		

In which country did the event occur?

MEDICAL HISTORY <small>(Past and current medical conditions, surgical procedures, allergies, pregnancy, lactation, family medical history, etc.)</small>	OTHER ONGOING MEDICATION <small>(Name, dose, frequency, route)</small>
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## REPORTER

Name:	<input type="text"/>	Is the reporter a healthcare provider?	Yes	No
Country:	<input type="text"/>	If not, please provide contact details of the patient's physician:		
E-mail:	<input type="text"/>	Physician's Name:	E-mail:	Phone:
Phone:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

To report the adverse event to Amgen, please save the form on your computer, complete it, and e-mail it to [australiansafety@amgen.com](mailto:australiansafety@amgen.com).