

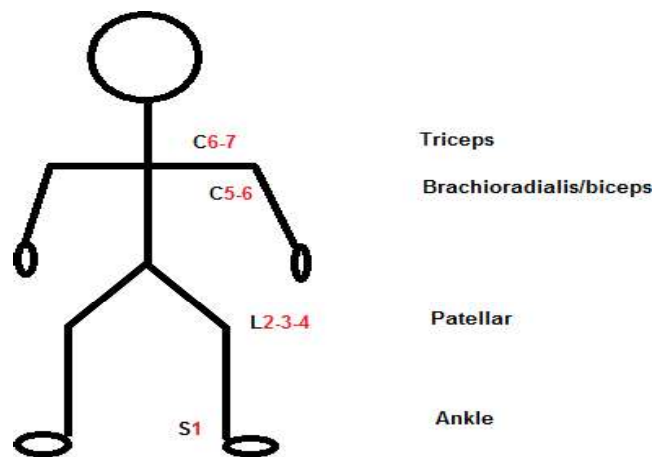
1. Reporter Details		<input type="checkbox"/> Initial	<input type="checkbox"/> Follow-up
Reporter Name:		E-mail:	
Contact address:		Telephone number:	
		Fax number:	
Type:	<input type="checkbox"/> Physician (Specialty): _____	<input type="checkbox"/> Consumer or other non healthcare professional	
	<input type="checkbox"/> Pharmacist	<input type="checkbox"/> Other (Specify) _____	
If reporter is a consumer, have they informed their physician of the exposure?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the consumer provided permission to contact their healthcare professional?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>If yes, please provide healthcare professional contact details:</b>			
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	
<input type="checkbox"/> Loss of sensation	<input type="checkbox"/> Tingling
<input type="checkbox"/> Lancination	<input type="checkbox"/> Muscle weakness
<input type="checkbox"/> Lack of coordination	<input type="checkbox"/> Numbness
<input type="checkbox"/> Pain	<input type="checkbox"/> Burning sensation
Other relevant symptoms	
<div style="height: 150px;"></div>	
<b>EXAMINATION of NERVOUS SYSTEM</b>	

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)**

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

**MOTOR SUBSCORES** **SENSORY SUBSCORES**

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

<input type="checkbox"/> Viral illness	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Autoimmune disease	<input type="checkbox"/> Kidney disorders
<input type="checkbox"/> Liver disorders	<input type="checkbox"/> Vascular and blood disorders
<input type="checkbox"/> Stroke	<input type="checkbox"/> Seizure
<input type="checkbox"/> Nerve injury	<input type="checkbox"/> Toxic exposure
<input type="checkbox"/> Anaesthesia use/Surgery	<input type="checkbox"/> Drug abuse
<input type="checkbox"/> Injury/ Trauma	<input type="checkbox"/> 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
			<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide dates of hospitalization.	<input type="checkbox"/> Recovered / Resolved <input type="checkbox"/> Recovered / Resolved with Sequelae <input type="checkbox"/> Recovering /Resolving <input type="checkbox"/> Not Recovered /Not Resolved <input type="checkbox"/> Fatal	<input type="checkbox"/> Related <input type="checkbox"/> Not Related <input type="checkbox"/> Unknown

**8. Details of Other Adverse Events**

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