U.S. Department of Health and Human Services

MedWatch

The FDA Safety Information and Adverse Event Reporting Program

For VOLUNTARY reporting of adverse events, product problems and product use errors

Page ____ of ____

Form Approved: OMB No. 0910-0291, Expires: 10/31/08
See OMB statement on reverse.

FDA USE ONLY

Triage unit sequence #

A. PATIENT INFORMATION

1. **Patient Identifier** In confidence
2. **Age at Time of Event, or Date of Birth:**
3. **Sex** ☐ Female ☐ Male
4. **Weight** _____ lb or _____ kg

B. ADVERSE EVENT, PRODUCT PROBLEM OR ERROR

Check all that apply:

1. ☐ **Adverse Event** ☐ **Product Problem** *(e.g., defects/malfunctions)*
☐ **Product Use Error** ☐ **Problem with Different Manufacturer of Same Medicine**

2. **Outcomes Attributed to Adverse Event** *(Check all that apply)*
☐ Death: _____ *(mm/dd/yyyy)* ☐ Disability or Permanent Damage
☐ Life-threatening ☐ Congenital Anomaly/Birth Defect
☐ Hospitalization - initial or prolonged ☐ Other Serious (Important Medical Events)
☐ Required Intervention to Prevent Permanent Impairment/Damage (Devices)

3. **Date of Event** *(mm/dd/yyyy)*
4. **Date of this Report** *(mm/dd/yyyy)*

5. **Describe Event, Problem or Product Use Error**

6. **Relevant Tests/Laboratory Data, Including Dates**

7. **Other Relevant History, Including Preexisting Medical Conditions** *(e.g., allergies, race, pregnancy, smoking and alcohol use, liver/kidney problems, etc.)*

C. PRODUCT AVAILABILITY

Product Available for Evaluation? *(Do not send product to FDA)*

☐ Yes ☐ No ☐ Returned to Manufacturer on: _____ *(mm/dd/yyyy)*

D. SUSPECT PRODUCT(S)

1. **Name, Strength, Manufacturer** *(from product label)*
#1
#2

2.

	Dose or Amount	Frequency	Route
#1			
#2			

3. **Dates of Use** *(If unknown, give duration) from/to (or best estimate)*
#1
#2

4. **Diagnosis or Reason for Use** *(Indication)*
#1
#2

5. **Event Abated After Use Stopped or Dose Reduced?**
#1 ☐ Yes ☐ No ☐ Doesn't Apply
#2 ☐ Yes ☐ No ☐ Doesn't Apply

6. **Lot #**
#1
#2

7. **Expiration Date**
#1
#2

8. **Event Reappeared After Reintroduction?**
#1 ☐ Yes ☐ No ☐ Doesn't Apply
#2 ☐ Yes ☐ No ☐ Doesn't Apply

9. **NDC # or Unique ID**

E. SUSPECT MEDICAL DEVICE

1. **Brand Name**
2. **Common Device Name**
3. **Manufacturer Name, City and State**
4. **Model #** **Lot #**
Catalog # **Expiration Date** *(mm/dd/yyyy)*
Serial # **Other #**
5. **Operator of Device**
☐ Health Professional
☐ Lay User/Patient
☐ Other: _____
6. **If Implanted, Give Date** *(mm/dd/yyyy)*
7. **If Explanted, Give Date** *(mm/dd/yyyy)*
8. **Is this a Single-use Device that was Reprocessed and Reused on a Patient?**
☐ Yes ☐ No
9. **If Yes to Item No. 8, Enter Name and Address of Reprocessor**

F. OTHER (CONCOMITANT) MEDICAL PRODUCTS

Product names and therapy dates *(exclude treatment of event)*

G. REPORTER *(See confidentiality section on back)*

1. **Name and Address**

Phone # **E-mail**

2. **Health Professional?** ☐ Yes ☐ No
3. **Occupation**
4. **Also Reported to:**
☐ Manufacturer
☐ User Facility
☐ Distributor/Importer
5. **If you do NOT want your identity disclosed to the manufacturer, place an "X" in this box:** ☐

PLEASE TYPE OR USE BLACK INK

 Submission of a report does not constitute an admission that medical personnel or the product caused or contributed to the event.

ADVICE ABOUT VOLUNTARY REPORTING

Detailed instructions available at: http://www.fda.gov/medwatch/report/consumer/instruct.htm

Report adverse events, product problems or product use errors with:

- Medications *(drugs or biologics)*
- Medical devices *(including in-vitro diagnostics)*
- Combination products *(medication & medical devices)*
- Human cells, tissues, and cellular and tissue-based products
- Special nutritional products *(dietary supplements, medical foods, infant formulas)*
- Cosmetics

Report product problems - quality, performance or safety concerns such as:

- Suspected counterfeit product
- Suspected contamination
- Questionable stability
- Defective components
- Poor packaging or labeling
- Therapeutic failures (product didn't work)

-Fold Here-

Report SERIOUS adverse events. An event is serious when the patient outcome is:

- Death
- Life-threatening
- Hospitalization - initial or prolonged
- Disability or permanent damage
- Congenital anomaly/birth defect
- Required intervention to prevent permanent impairment or damage
- Other serious (important medical events)

Report even if:

- You're not certain the product caused the event
- You don't have all the details

How to report:

- Just fill in the sections that apply to your report
- Use section D for all products except medical devices
- Attach additional pages if needed
- Use a separate form for each patient
- Report either to FDA or the manufacturer *(or both)*

Other methods of reporting:

- 1-800-FDA-0178 -- To FAX report
- 1-800-FDA-1088 -- To report by phone
- www.fda.gov/medwatch/report.htm -- To report online

If your report involves a serious adverse event with a device and it occurred in a facility outside a doctor's office, that facility may be legally required to report to FDA and/or the manufacturer. Please notify the person in that facility who would handle such reporting.

-Fold Here-

If your report involves a serious adverse event with a vaccine call 1-800-822-7967 to report.

Confidentiality: The patient's identity is held in strict confidence by FDA and protected to the fullest extent of the law. FDA will not disclose the reporter's identity in response to a request from the public, pursuant to the Freedom of Information Act. The reporter's identity, including the identity of a self-reporter, may be shared with the manufacturer unless requested otherwise.

The public reporting burden for this collection of information has been estimated to average 36 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to:

Department of Health and Human Services
Food and Drug Administration - MedWatch
10903 New Hampshire Avenue
Building 22, Mail Stop 4447
Silver Spring, MD 20993-0002

Please DO NOT RETURN this form to this address.

OMB statement:
"An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number."

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Food and Drug Administration

FORM FDA 3500 (10/05) (Back) **Please Use Address Provided Below -- Fold in Thirds, Tape and Mail**

DEPARTMENT OF
HEALTH & HUMAN SERVICES

Public Health Service
Food and Drug Administration
Rockville, MD 20857

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Food and Drug Administration
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