Adverse Drug Event (ADE) Reporting Form

ADE: an event that results in harm or injury to the patient due to medication use.

PATIENT NAME _____

DOB _____ TIME _____ DATE _____

MEDICATION CAUSING ADE _____

Patient received last dose of suspected medication: **TIME** _____ **DATE** _____

CENTRAL NERVOUS SYSTEM
- ☐ Agitation
- ☐ Anxiety
- ☐ Depression
- ☐ Drowsiness
- ☐ Fall
- ☐ Fatigue
- ☐ Hallucinations
- ☐ Headache
- ☐ Insomnia
- ☐ Malaise
- ☐ Nervousness
- ☐ Nightmares
- ☐ Pain
- ☐ Tinnitus
- ☐ Vertigo

SENSORY
- ☐ Altered hearing
- ☐ Altered taste
- ☐ Altered vision

RESPIRATORY
- ☐ Bronchospasm
- ☐ Cough
- ☐ Nasal congestion

MISCELLANEOUS
- ☐ Bleeding
- ☐ Fever
- ☐ Lab changes
  Explain: _____
  _____
  _____
- ☐ Low blood glucose

CARDIOVASCULAR
- ☐ Angina
- ☐ Arrhythmia (other)
- ☐ Bradycardia
- ☐ CHF
- ☐ Hypertension
- ☐ Hypotension
- ☐ Palpitations
- ☐ Tachycardia
- ☐ Shock
- ☐ Syncope

GASTROINTESTINAL
- ☐ Anorexia
- ☐ Ascites
- ☐ Constipation
- ☐ Cramping
- ☐ Diarrhea
- ☐ Dry mouth
- ☐ Flatulence
- ☐ Hematemesis
- ☐ Indigestion
- ☐ Jaundice
- ☐ Nausea/vomiting

GENITOURINARY SYSTEM
- ☐ Altered renal status
- ☐ Difficult voiding
- ☐ Hematuria
- ☐ Other: _____
  _____
  _____

DERMATOLOGIC
- ☐ Bruising
- ☐ Flushing
- ☐ Hives
- ☐ Itch
- ☐ Perspiration
- ☐ Rash

PLEASE RETURN THIS COMPLETED FORM TO THE DIRECTOR OF NURSING

TREATMENT:
- ☐ **Drug discontinued**
- ☐ **Dose changed** _____
- ☐ **Antidote given** _____

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