|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **DATOS DE INFORMANTE** | | | | |
| **¿Desea ser contactado por el área de Farmacovigilancia para su seguimiento?** | | | | |
|  | **Sí** |  | **No** | |
|  | | | | |
| **Nombre** | | | |  |
|  | | | | |
| **Teléfono** | | | |  |
|  | | | | |
| **E-mail** | | | |  |
|  |  |  |  |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **DATOS DE PACIENTE** | | | | | | | | |
| **Nombre (iniciales)** |  | | |  | | | |  |
| Nombre(s) | | | Apellido paterno | | | | Apellido materno |
|  | | | | | | | | |
| **Fecha de nacimiento** |  | | |  | | | |  |
| *Día* | | | *Mes* | | | | *Año* |
|  | | | | | | | | |
| **Sexo** |  |  | **Masculino** | |  |  | **Femenino** | |

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| --- | --- | --- | --- |
| **INFORMACIÓN DEL MEDICAMENTO SOSPECHOSO** | | | |
| **Nombre** |  | | |
|  | | | |
| **Lote** |  | | |
|  | | | |
| **Fecha de inicio de tratamiento** |  |  |  |
| *Día* | *Mes* | *Año* |
|  | | | |
| **Vía de administración** |  | | |
|  | | | |
| **Dosis** |  | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **SOSPECHA DE REACCIÓN ADVERSA A MEDICAMENTO** | | | |
| **Fecha de inicio de reacción** |  |  |  |
| *Día* | *Mes* | *Año* |
|  | | | |
| **Descripción breve de la sospecha de reacción adversa** |  | | |