



TITLE REFERENCE

PHARMACOVIGILANCE FILE FOR MEDICAL VISITORS/ REGIONAL DIRECTORS

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URGENT!

TO RETURN IN 24H TO FRILAB SA to the email address:

pharmacovigilance@frilab.ch

Date of receipt of the case:

I. YOUR COORDINATES

Last, first name:	
Address :	
Country :	
Tel :	Fax:
Email :	

II. MEDICINES(S) SUSPECT(S)

If possible, write down the lot number (s) and expiration date (s).

III. NOTIFIER

Last, first Name:	
Address:	
Country:	
Tel :	Fax:
Email:	

IV. PATIENT

INITIALS (first 3 letters):	
Sex: <input type="checkbox"/> Man <input type="checkbox"/> Woman	Age:

V. DESCRIPTION



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