

PRODUCT COMPLAINT FORM

DEPARTMENT OF HEALTH: WESTERN CAPE

MEDICINE COMPLAINT FORM

PLEASE NOTE:

This form does NOT replace the "Report on Suspected Adverse Drug Event" form to the Medicine Information Centre and should an adverse drug reaction be observed that form should be completed and sent to the Medicine Information Centre. (Refer to Annexure 22 of the Policy and Procedure Manual for Hospital Pharmacists")

FACILITY **DATE**

- 1 Name of person lodging complaint:.....
- 1.1 Qualifications:.....Designation :.....
- 1.2 Signature:.....
- 1.3 Department:.....

2. NATURE OF COMPLAINT: Delete which is not applicable

- Poor quality of preparation
- Poor quality of packaging
- Ineffective medicine expected/claimed effect not attained
- Unstable medicine
- Other(please specify)

Please report fully (if possible, sample of product or empty container to be submitted to the Provincial Office with Complaint form).

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3. INFORMATION ON PRODUCT

- 3.1 Catalogue number:
- 3.2 Trade name of product:.....
- 3.3 Name of manufacturer:.....
- 3.4 Generic description:.....
- 3.5 Strength:.....

- 3.6 Dosage form: (tablet injection
etc.).....
- 3.7 Batch number and expiry
date:.....

PLEASE RETURN THE COMPLETE FORM TO THE PHARMACIST OR HEALTH WORKER IN CHARGE OR THE INSTITUTION, WHO WILL FORWARD THE FORM TO THE HEAD: PHARMACY SERVICES