NRDIOSE ADVERSE REACTION CASE REPORT FORM

Please complete & return by:

FAX: 503-494-3929
EMAIL: eyedrug@ohsu.edu

Patient Identifier (confidential):		Gender:		Age:	
Suspected Ocular or Systemic Reaction:					
Estimated Days/Months to Onset of Side Effect:		Outcome:			
Relevant Tests/Lab Work:					
Suspected Drug: (Generic name preferred)					
Daily Dose:		Route of Administration:			
Indication for Use:					
Did the reaction disappear if the drug was stopped?	☐ Yes ☐ No ☐ NA	Did the reaction reappear if the drug was restarted?	☐ Yes ☐ No ☐ NA		
Other Relevant History:					
Your Contact Information: (optional, but encouraged)	Name:				
	Email:				