

1. Reporter Details		<input type="checkbox"/> Initial	<input type="checkbox"/> Follow-up
Reporter Name:		E-mail:	
Contact address:		Telephone number:	
		Fax number:	
Type:	<input type="checkbox"/> Physician (Specialty): _____		<input type="checkbox"/> Consumer or other non healthcare professional
	<input type="checkbox"/> Pharmacist		<input type="checkbox"/> Other (Specify) _____
If reporter is a consumer, have they informed their physician of the exposure?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the consumer provided permission to contact their healthcare professional?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please provide healthcare professional contact details:			
Name:		Type:	Telephone:
Address:		Email:	

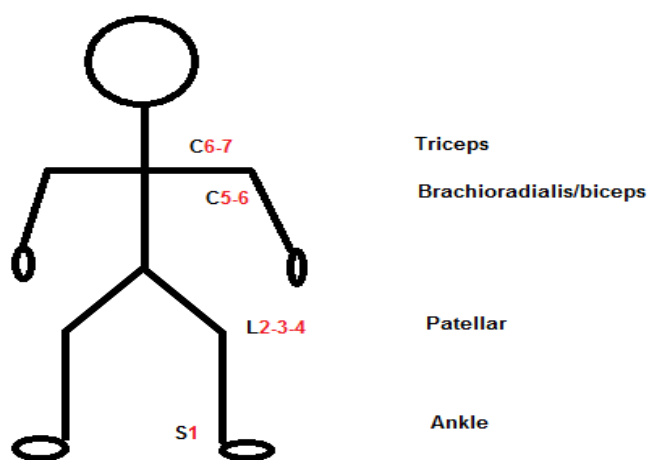
2. Patient Details			
Date of birth (Day/Month/Year)	Age Yrs/mo.	Height (cm)	Weight (kg)

3. Suspect Product Details									
	Name	Strength	Dos e	Route	Indicat ion	Treatment Start date (day/month/year)	Treatment end date (day/month/year)	Lot	Exp. date
1.									
2.									
3.									

4. Peripheral Neuropathy Assessment	
Symptoms	
<input type="checkbox"/> Loss of sensation	<input type="checkbox"/> Tingling
<input type="checkbox"/> Lancination	<input type="checkbox"/> Muscle weakness
<input type="checkbox"/> Lack of coordination	<input type="checkbox"/> Numbness
<input type="checkbox"/> Pain	<input type="checkbox"/> Burning sensation
Other relevant symptoms	
EXAMINATION of NERVOUS SYSTEM	

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DEEP REFLEXES	TENDON	Right	Left
Biceps			
Triceps			
Brachioradialis			
Knee Jerk			
Ankle Jerk			
OTHER REFLEXES		Right	Left
Plantar Response			
Superficial Reflexes			
Cranial Nerves			



SENSORY EXAMINATION

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RIGHT **MOTOR KEY MUSCLES** **SENSORY KEY SENSORY POINTS** **SENSORY KEY SENSORY POINTS** **MOTOR KEY MUSCLES** **LEFT**

UER (Upper Extremity Right) **UEL** (Upper Extremity Left)

LER (Lower Extremity Right) **LEL** (Lower Extremity Left)

RIGHT TOTALS (MAXIMUM) (50) (56) (56) **LEFT TOTALS** (MAXIMUM) (50) (56) (56)

MOTOR SUBSCORES **SENSORY SUBSCORES**

UER + UEL = UEMS TOTAL LER + LEL = LEMS TOTAL LTR + LTL = LT TOTAL PPR + PPL = PP TOTAL

MAX (25) (25) (50) MAX (25) (25) (50) MAX (56) (56) (112) MAX (56) (56) (112)

NEUROLOGICAL LEVELS **3. NEUROLOGICAL LEVEL OF INJURY (NLI)** **4. COMPLETE OR INCOMPLETE?** **5. ASIA IMPAIRMENT SCALE (AIS)**

1. SENSORY R L 2. MOTOR R L Incomplete = Any sensory or motor function in S4-5 (In complete injuries only) ZONE OF PARTIAL PRESERVATION Sensory R L Motor R L

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5. Test Results			
	Date (day/month/year)	Results	Normal Range
Nerve conduction studies			
Other relevant test details:			

6. Medical History

Patient's concomitant conditions, relevant medical history, known risk factors, relevant tests, and laboratory data.

<input type="checkbox"/> Viral illness	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Autoimmune disease	<input type="checkbox"/> Kidney disorders
<input type="checkbox"/> Liver disorders	<input type="checkbox"/> Vascular and blood disorders
<input type="checkbox"/> Stroke	<input type="checkbox"/> Seizure
<input type="checkbox"/> Nerve injury	<input type="checkbox"/> Toxic exposure
<input type="checkbox"/> Anaesthesia use/Surgery	<input type="checkbox"/> Drug abuse
<input type="checkbox"/> Injury/ Trauma	<input type="checkbox"/> Alcohol use: Glass/day

Other relevant medical history:

Risk Factors

7. Treatment

Treatment provided for the Peripheral Neuropathy:

8. Details of Other Adverse Events

Adverse Event	Start Date (day/month/year)	Stop Date (day/month/year)	Hospitalization	Outcome	Event Causality
			<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide dates of hospitalization.	<input type="checkbox"/> Recovered / Resolved <input checked="" type="checkbox"/> Recovered / Resolved with Sequelae <input type="checkbox"/> Recovering /Resolving <input type="checkbox"/> Not Recovered /Not Resolved <input type="checkbox"/> Fatal	<input type="checkbox"/> Related <input type="checkbox"/> Not Related <input type="checkbox"/> Unknown

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8. Details of Other Adverse Events					
Adverse Event	Start Date (day/month/year)	Stop Date (day/month/year)	Hospitalization	Outcome	Event Causality
				<input type="checkbox"/> Unknown	
			<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide dates of hospitalization.	<input type="checkbox"/> Recovered / Resolved <input type="checkbox"/> Recovered / Resolved with Sequelae <input type="checkbox"/> Recovering /Resolving <input type="checkbox"/> Not Recovered /Not Resolved <input type="checkbox"/> Fatal <input type="checkbox"/> Unknown	<input type="checkbox"/> Related <input type="checkbox"/> Not Related <input type="checkbox"/> Unknown
			<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide dates of hospitalization.	<input type="checkbox"/> Recovered / Resolved <input type="checkbox"/> Recovered / Resolved with Sequelae <input type="checkbox"/> Recovering /Resolving <input type="checkbox"/> Not Recovered /Not Resolved <input type="checkbox"/> Fatal <input type="checkbox"/> Unknown	<input type="checkbox"/> Related <input type="checkbox"/> Not Related <input type="checkbox"/> Unknown

9. Concomitant Drugs & Therapies

10. Completed By		
Name:	Signature:	Date (day/month/year):

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