

Medication and Device Experience Report

(continued)

Refer to guidelines for specific instructions

Submission of a report does not constitute an admission that medical personnel, user facility, distributor, manufacturer or product caused or contributed to the event.

Page ____ of ____

FDA Use Only

F. For use by user facility/distributor – devices only	
1. Check one <input type="checkbox"/> user facility <input type="checkbox"/> distributor	2. UF/Dist report number
3. User facility or distributor name/address	
4. Contact person	5. Phone Number
6. Date user facility or distributor became aware of event (mo/day/yr)	7. Type of report <input type="checkbox"/> initial <input type="checkbox"/> follow-up # _____
8. Date of this report (mo/day/yr)	
9. Approximate age of device	10. Event problem codes (refer to coding manual) patient code _____ - _____ - _____ device code _____ - _____ - _____
11. Report sent to FDA? <input type="checkbox"/> yes _____ (mo/day/yr) <input type="checkbox"/> no	12. Location where event occurred <input type="checkbox"/> hospital <input type="checkbox"/> outpatient diagnostic facility <input type="checkbox"/> home <input type="checkbox"/> ambulatory surgical facility <input type="checkbox"/> nursing home <input type="checkbox"/> outpatient treatment facility <input type="checkbox"/> other: _____ specify
13. Report sent to manufacturer? <input type="checkbox"/> yes _____ (mo/day/yr) <input type="checkbox"/> no	
14. Manufacturer name/address	

G. All manufacturers	
1. Contact office – name/address (& mfring site for devices)	2. Phone number
	3. Report source (check all that apply) <input type="checkbox"/> foreign <input type="checkbox"/> study <input type="checkbox"/> literature <input type="checkbox"/> consumer <input type="checkbox"/> health professional <input type="checkbox"/> user facility <input type="checkbox"/> company representative <input type="checkbox"/> distributor <input type="checkbox"/> other: _____
4. Date received by manufacturer (mo/day/yr)	5. (A)NDA # _____ IND # _____ PLA # _____ pre-1938 <input type="checkbox"/> yes OTC product <input type="checkbox"/> yes
6. If IND, protocol #	
7. Type of report (check all that apply) <input type="checkbox"/> 5-day <input type="checkbox"/> 15-day <input type="checkbox"/> 10-day <input type="checkbox"/> periodic <input type="checkbox"/> Initial <input type="checkbox"/> follow-up # _____	
9. Mfr. report number	8. Adverse event term(s)

H. Device manufacturers only	
1. Type of reportable event <input type="checkbox"/> death <input type="checkbox"/> serious injury <input type="checkbox"/> malfunction (see guidelines) <input type="checkbox"/> other: _____	2. If follow-up, what type? <input type="checkbox"/> correction <input type="checkbox"/> additional information <input type="checkbox"/> response to FDA request <input type="checkbox"/> device evaluation
3. Device evaluated by mfr? <input type="checkbox"/> not returned to mfr. <input type="checkbox"/> yes <input type="checkbox"/> evaluation summary attached <input type="checkbox"/> no (attach page to explain why not) or provide code: _____	4. Device manufacture date (mo/yr)
	5. Labeled for single use? <input type="checkbox"/> yes <input type="checkbox"/> no
6. Evaluation codes (refer to coding manual) method _____ - _____ - _____ - _____ results _____ - _____ - _____ - _____ conclusions _____ - _____ - _____ - _____	
7. If remedial action initiated, check type <input type="checkbox"/> recall <input type="checkbox"/> notification <input type="checkbox"/> repair <input type="checkbox"/> inspection <input type="checkbox"/> replace <input type="checkbox"/> patient monitoring <input type="checkbox"/> relabeling <input type="checkbox"/> modification/adjustment <input type="checkbox"/> other: _____	8. Usage of device <input type="checkbox"/> initial use of device <input type="checkbox"/> reuse <input type="checkbox"/> unknown
	9. If action reported to FDA under 21 USC 360i(f), list correction/removal reporting number:

10. <input type="checkbox"/> Additional manufacturer narrative	and/or	11. <input type="checkbox"/> Corrected data
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The public reporting burden for this collection of information has been estimated to average one hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to:

DHHS Reports Clearance Office
Paperwork Reduction Project (0910-0291)
Hubert H. Humphrey Building, Room 531-H
200 Independence Avenue, S.W.
Washington, D.C. 20201

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