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| **PACIENTE:** |  |  | **CONCEPTO** |  |  | **RECIBIÓ:** |  |  | **FECHA** |  |  |
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|  | FORMATO DE REPORTE DE SOSPECHA DE REACCIÓN ADVERSA A MEDICAMENTOS | | | | | | | | |  |  |

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| **1. IDENTIFICACIÓN:** | | | |  | |  | | |  |  | |  | |  | |  | |  | | |
| **FECHA DE NOTIFICACIÓN** | | | | **INSTITUCIÓN** | | **NIVEL** | | | **ORIGEN (CIUDAD-MUNICIPIO)** | | | | | | | | | | |
| **D** | **M** | **A** |  | |  | | |  | | | | | | | | | | |
| **NOMBRE DEL PACIENTE** | | | | | | | | | | | | | | | | | | | |
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| **HISTORIA CLÍNICA** | | | | **No. IDENTIFICACIÓN** | | | **PESO** | | | | **SEXO** | | **FECHA DE NACIMIENTO (MENORES DE EDAD)** | | | | | |
|  | | | |  | | |  | | | | **F M** | | **D** | | **M** | | **A** | |

**2. DESCRIPCIÓN DE LAS REACIONES ADVERSAS: En caso de existir otras sospechas de RAMs por favor escriba la fecha de inicio para cada una**

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| **FECHA DE INICIO RAMs SOSPECHADA(S)** | **D** | **M** | **A** |  |  |  |  |  |  |  |  |
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| **3. MEDICAMENTO: Marque con una X él o los medicamentos sospechosos en la columna (S)** | | | | | | | | | | |  |
| **S** | **MEDICAMENTOS** | **DOSIS/FRECUENCIA VÍA DE ADMINISTRACIÓN** | | | **DOSIS INICIAL** | **DOSIS FINAL** | **DESENLACE DEL EVENTO** | **GRAVEDAD** | **MOTIVO DE LA PRESCRIPCIÓN** | **FECHA INICIO** | **FECHA FINAL** |
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| **4. DATOS DEL MEDICAMENTO:** | | | |
| **REGISTRO SANITARIO** | **LOTE** | **FECHA DE VENCIMIENTO** | **PAÍS** |
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