Arcolab

MI/PQC REQUEST FORM

Case Type (all applicable) ☐ AE ☐ MI ☐ PQC ☐ Replacement ☐ Refund Requested by: _____

Report sequence ☐ initial ☐ follow up

Reporter Data					
Last Name		First name			Middle initial
Address:		City:	State:	Zip code:	Country:
Phone number:	Fax number:	Email:	Institution:	Country of occurrence:	
Primary Reporter: ☐ Yes ☐ No		Healthcare Professional: ☐ yes ☐ No		HCP Category:	

Primary contact:		Name of the pharmacy:	
Last Name:		First Name:	Middle Initials:
Address:		City: / State:	Zip Code:
		Country:	
Phone number:	Fax number:	Email:	

Product Information		
Product Name:	Strength:	Dosage form:
Package size: Packages:	Batch/Lot #:	Expiration Date:
Did the reporter contact before: ☐ Yes ☐ No		Date of previous contact:
Narrative: Provide the clear description of the sequence of events, and any other relevant details		

Prepared by: _____
Date & Sign: _____