FILLMED
LABORATOIRES

Adverse Reaction/Incident Form

When did the reaction/incident occur? (dd/mm/yyyy):

State/Country where the reaction/incident occurred? (please tick)

☐ NSW ☐ VIC ☐ TAS ☐ SA ☐ WA ☐ QLD ☐ NZ

Where did you purchase the product/s?

Clinic Name: ______________________

Clinic Email Address: ______________________

Product Used: ______________________

Batch Number: ______________________

Second Product Used: ______________________

Batch Number: ______________________

Third Product Used: ______________________

Batch Number: ______________________

Fourth Product Used: ______________________

Batch Number: ______________________

Fifth Product Used: ______________________

Batch Number: ______________________

Sixth Product Used: ______________________

Batch Number: ______________________

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How did the incident occur?

Describe the Adverse reaction/incident

How long after using the product did the adverse reaction occur?

Which other cosmetic products and/or medications were the client using a week before the adverse reaction?

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Did the client need to see a doctor or other medical professional (nurse/pharmacist/etc)?

☐ YES ☐ NO

Did the adverse reaction require a prescribed treatment by a medical practitioner?

☐ NO ☐ YES (if YES, What was prescribed?)

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Has the client recovered from the adverse reaction?

☐ YES ☐ NO

Has the client had any history of skin sensitivity/allergic reaction?

☐ YES ☐ NO

Additional information or comments?

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Gender

☐ MALE ☐ FEMALE ☐ OTHER

Age: ______________________________

Full Name: ______________________________

Contact details: ______________________________

Phone: ______________ Email: ______________

Do we have the person's consent to provide these details to regulatory authorities (eg ACCC/TGA) if required?

☐ YES ☐ NO

Please provide your name and details

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Please attach images of the affected area or relevant documentation