SULTANATE OF OMAN
MINISTRY OF HEALTH
DIRECTORATE GENERAL OF MEDICAL SUPPLIES

DRUG QUALITY REPORTING FORM

Name of Hospital/ H.C./ E.H.C.: ……………………………………………………………………

Product:

Trade Name……………………………………**Generic Name**……………………………………

Strength…………………..……**Dosage form**……………………**Item code**…………….………

Batch No…………………..……**Mfg.date**……………………….**Expiry date**……………….…..

Manufacturer & Country of Origin:……………………………………………………………

Quality Problem(s):

( ) **Not effective :** Patient's Complaint ☐ Clinical evaluation ☐

Specify ………………………………………………………………………………………..

………………………………………………………………………………………………..

( ) **Non–compliance with specifications :** Chemical ☐ Physical ☐ Microbial ☐

Specify ………………………………………………………………………………………..

………………………………………………………………………………………………..

( ) **Difficulty in use :** Taste ☐ Odour ☐ Size ☐

Opening ☐ Closure ☐ Storage ☐ Others ☐

Specify ………………………………………………………………………………………..

………………………………………………………………………………………………..

( ) **Packaging Materials :** Look-alike ☐ Outer pack ☐ Inner pack ☐

Cartons ☐ Poor Quality ☐ Detailed inscription not printed ☐

Specify ………………………………………………………………………………………..

………………………………………………………………………………………………..

( ) **Pack Insert :** Required information not available ☐ Others ☐

Specify ………………………………………………………………………………………..

………………………………………………………………………………………………..

Tick (✓) in case of quality problem; specify details and forward defected samples of drug/s as applicable.

Reporter name …………………………………………..**Designation**…………………………….…

Signature …………………………….. …………

Date ……………………………………………… **Hospital stamp**

Note: To be filled in by the Physician, Pharmacist / Assistant Pharmacist or Nursing Staff concerned and forwarded through the Director / Supdt. / Head of Pharmacy & Medical Stores to The Head, Co-ordination & Follow up, DGMS, MOH, Muscat. Fax: 24601593.