## Drug Quality Reporting Form

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

<table>
<thead>
<tr>
<th>Product:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Trade Name</td>
<td>Generic Name</td>
</tr>
<tr>
<td>Strength</td>
<td>Dosage form</td>
</tr>
<tr>
<td>Batch No</td>
<td>Mfg. date</td>
</tr>
</tbody>
</table>

**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.