



**Veterinary Medicines Directorate**  
 FREEPOST KT 4503, Woodham Lane,  
 New Haw, Addlestone,  
 Surrey KT15 3BR  
 Tel. No.: 01932 338427 Fax: 01932 336618

**IN CONFIDENCE**

**For Official Use Only**

Adverse reaction number

SAR file

Date received

Date acknowledged

**Suspected Adverse Reaction Surveillance Scheme (SARSS)**  
**Animal suspected adverse reaction report**

- This form should be completed in **BLOCK LETTERS** if hand written and sent to the FREEPOST address given above, whenever a suspected adverse reaction is observed in **animals** (including birds and fish) during or after the use of veterinary medicine.

**All Reporters MUST complete this section**

Full name of product

Product number (on label)\*  Batch number

*\*The product number is preceded by Vm, MA or EU*

This form will be copied to the Company (Marketing Authorisation holder) in order that they are aware of any reported suspected adverse reaction to their product. They may wish to contact you for further details. If you do not want the name(s) and address(es) on the form to be revealed to the Company, please tick this box

**Has the Company already been informed?** YES  NO

Your reference number (if any)

Full name and address of the person sending this form to VMD

County:

Postcode:  Date:

Full address where reaction(s) occurred

County:

Postcode:

Full name and address of veterinarian involved

County:

Postcode:

**Details of animal suspected adverse reaction(s)**

Reasons for using product

No. of animals treated on this occasion  No. of animals reacting  No. of deaths  Actual amount of product administered

Administered by (occupation)  Date of first administration  Duration of treatment

Site and route of administration  Previous use of product in this animal(s) YES  NO  If YES, number of occasions

Date of reaction(s)	Species/Breed	Weight kg	Age	Sex (M/F)	Nature of reaction including time of onset and duration of symptoms (continue on page 2 if necessary)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Full details of products given concurrently (if any)

Immediate treatment given (if any)

Previous vaccination history (if immunological product involved in suspected adverse reaction) product no.\* and batch no.

**Post mortem and/or laboratory tests:**

Have any post mortems or relevant diagnostic tests been performed? ..... YES  NO   
 If YES, please attach copies or forward to VMD in due course

**Comments:**

If you have any comments or further information, please continue on page 2.

**Receipt of this form will be acknowledged**

**FURTHER COMMENTS AND INFORMATION (if required)**