Report of a Suspected Serious Adverse Reaction in a Recipient of a transplant

Name and address of the tissue establishment:

DIZG Deutsches Institut für Zell- und Gewebeersatz gGmbH / DIZG German Institute for Cell and Tissue Replacement, a non-profit limited liability company
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D-12555 Berlin
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1. Address of the reporting hospital / clinic / medical practice / pharmacy

Name _____ Department / Station _____

Street, No. _____ ZIP Code, City _____

Phone No. _____ Email Address _____

2. Name of the transplant

_____

3. Charge number (Ch.-B.) of the transplant

4. Transplant ID No.

5. Single European Code (SEC)

6. Recipient's (patient) initials

7. Date of birth (patient)

8. Gender of recipient (patient)

□ Female □ Male □ Diverse

9. Underlying disease of recipient (patient)

_____

_____

10. Indication for transplantation

_____

_____

11. Date of surgery

Date (DD.MM.YYYY)

12. Details of the serious adverse reaction

13. Date of onset of the reaction

Date (DD.MM.YYYY)

14. Date of resolution of the reaction

Date (DD.MM.YYYY)

15. Outcome of the reaction

☐ Recovered ☐ Recovered with sequelae

☐ Death Cause of death: _____

16. Course and treatment

(If applicable, attach an informal document such as a report or doctor's note)

Date

Signature of the person filing the report

If applicable, stamp from the hospital, clinic, medical practice, or pharmacie