Dental Adverse Reactions Reporting Form

- This form can be used for patient or occupational adverse reactions
- Please report all suspected adverse reactions, including minor ones

Data regarding person affected:

Reporter's identification of affected person: ______________________

Person affected is: Patient Dentist Dental nurse
Dental hygienist Dental technician Other: _______________

Age: under 20 20-29 30-39 40-49 50-59 60+

Gender: Male Female

Was the adverse reaction first noticed by? Affected person Yourself

What month/year was the reaction first noticed: Month ____ Year ____

If the reaction occurred after dental treatment/handling dental materials, did it occur:

within 1 hour within 1 day within 1 week
within 1 month months to years unknown

General diseases:

Medications:

Known allergies:

Reactions: (objective findings and subjective symptoms)

Local reaction – intra-oral:

Reaction – lip/face:

General reaction (other than mouth, lip and face):

PTO

Type of material(s) suspected:

____

Suspected products: (state brand name and manufacturer if known)

____

Type of dental treatment(s) suspected:

Fillings
Inlays, veneers
Dentures
Crowns and bridges
Endodontic treatment
Temporary restorations
Periodontal treatment
Oral surgery
Orthodontics
Preventive dentistry
Not applicable
Other (please specify):

Assessment of relationship:

Reporter's assessment of relationship between material(s) and reaction(s):

Probable Possible Uncertain Unlikely

Affected person's assessment of relationship between material(s) and reaction(s):

Probable Possible Uncertain Unlikely

Degree of the reaction:

Mild Moderate Severe

Referrals:

Has or will the affected person be referred for further investigation? No Yes
If "yes" to whom?

General practitioner
Dentist
Dermatologist
Allergist
Oral physician
Other (please specify):

Reporter's details:

(Please print clearly)

Title: _________

Name: __________________

Address: _________________________

____

____

Post code: ______________________

Dentist Physician
Hygienist Dental technician
Dermatologist
Other (please specify):

____

Telephone: _______________________

Email: ___________________________

Date: ___________________________

Number of additional form(s) required:

____

Postal address:
Adverse Reaction Reporting Project (ARRP),
The University of Sheffield,
Department of Restorative Dentistry,
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Contact information:
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