

ADRMS

(Adverse Drugs Reaction Monitoring System)

By Indian pharmacopoeia commission (IPC), ministry of Health & Family Welfare, Govt.of India

UNREGISTER CONSUMER

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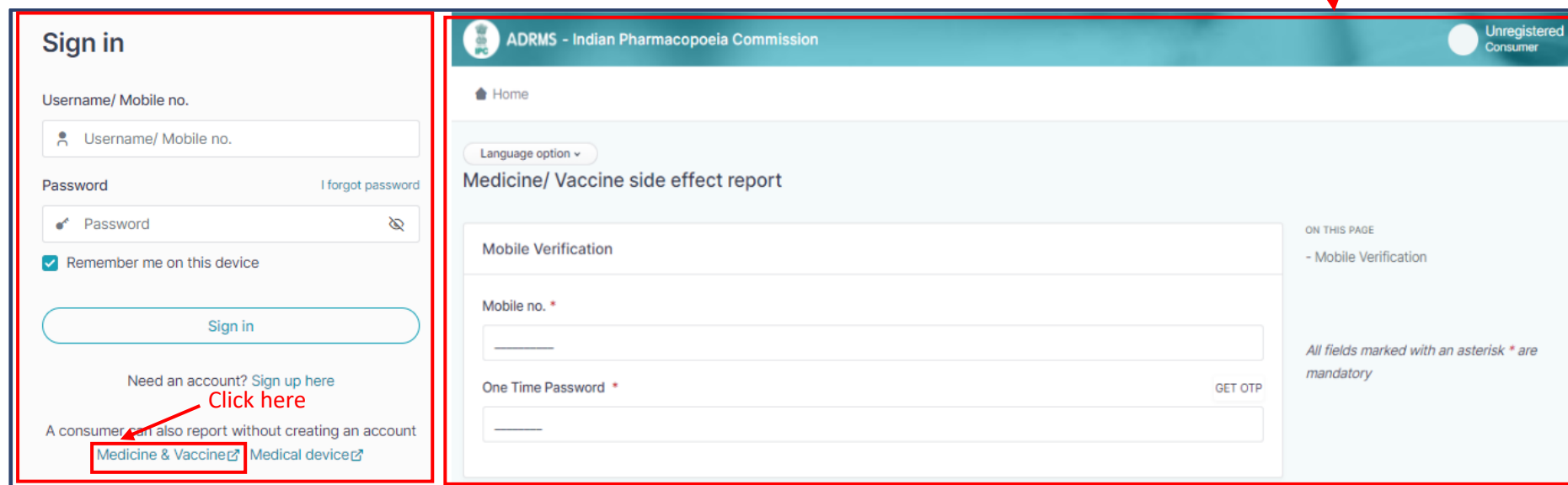
1. How Submit Medicine/Vaccine side effect report

Introduction:

Unregistered Consumer means, Consumer can submit report without creating an account. Reports are Medicine/Vaccine side effect report and Medical device side effect report. This is very simple step for consumer.

Step 1: Click on **Medicine & Vaccine**. Mobile Verification window will appear.

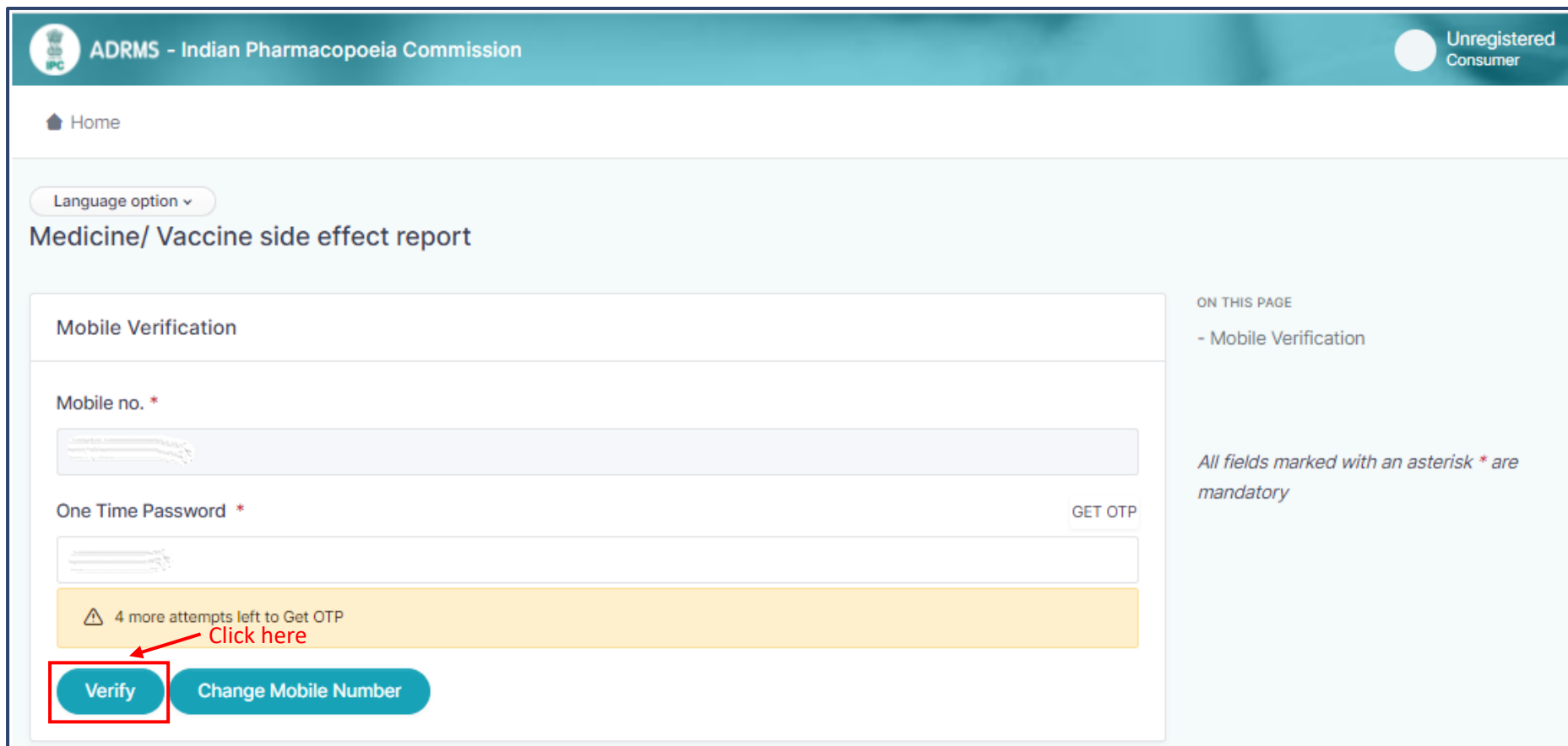
Mobile verification window



The screenshot displays the ADRMS - Indian Pharmacopoeia Commission website. On the left, a 'Sign in' form is visible with fields for 'Username/ Mobile no.' and 'Password', a 'Remember me on this device' checkbox, and a 'Sign in' button. Below the form, there is a link for 'Need an account? Sign up here' and a red arrow pointing to the 'Medicine & Vaccine' link. The main content area features a 'Mobile Verification' window with fields for 'Mobile no. *' and 'One Time Password *', and a 'GET OTP' button. A 'Language option' dropdown is also present. The top right corner shows the user is an 'Unregistered Consumer'. A red arrow points from the text 'Mobile verification window' to the top of the verification form.

Hindi and English two language options are available.

Step 2: Enter Mobile no. and OTP. Click on **Verify**. Medicine/Vaccine side effect report will open.



ADRMS - Indian Pharmacopoeia Commission

Unregistered Consumer

Home

Language option v

Medicine/ Vaccine side effect report

Mobile Verification

Mobile no. *

One Time Password * GET OTP

⚠ 4 more attempts left to Get OTP [Click here](#)

Verify Change Mobile Number

ON THIS PAGE
- Mobile Verification

All fields marked with an asterisk * are mandatory

Following Table for Mobile verification of Medicine/Vaccine side effect report field list:

Serial no.	Field name	Purpose	Is field required
1	Mobile no.	Valid 10 digit mobile no.	Yes:required
2	One Time Password	8 digit OTP on mobile number	Yes:required

Table1: Mobile verification of Medicine/Vaccine side effect report field list

In report there are Initial details, patient details, Health details, Side effect details, Medicine/Vaccine taken/taking details, Upload relevant document these 6 sections are present.

I. Initial details

II. Patient details

III. Health details

IV. Side effect details

V. Medicine/Vaccine taken/taking details

VI. Upload relevant document (these all are link to jump on respective section)

*All fields marked with an asterisk * are mandatory.*

English, Hindi two language are available

I. Initial details: Is this serious case? **Yes**. More than one Seriousness reasons can be select.

ADRMS - Indian Pharmacopoeia Commission
Unregistered Consumer

Home

Language option ▾

Medicine/ Vaccine side effect report

I. Initial details

Is this a serious case? *

Yes
▾

Seriousness reasons *

Results in death ×
Life threatening ×
Caused/ Prolonged hospitalization ×

Disabling/ Incapacitating ×
Congenital anomaly/birth defect ×

Other medically important condition ×

ON THIS PAGE

- I. Initial details
- II. Patient details
- III. Health details
- IV. Side effect details
- V. Medicine/ Vaccine taken/ taking details
- VI. Upload relevant document

I. Initial details: Is this serious case? No.

Language option ▾

Medicine/ Vaccine side effect report

I. Initial details

Is this a serious case? * Select

No ▾

ON THIS PAGE

- I. Initial details
- II. Patient details
- III. Health details
- IV. Side effect details
- V. Medicine/ Vaccine taken/ taking details
- VI. Upload relevant document

II. Patient details: Are you patient? Yes.

II. Patient details

Are you a patient? *

Yes No, Somebody else is a patient

Select

First name Last name Initials ? *

Date of birth/ Age *

Gender * Weight kg

Address 0/150 Pin code *

District * State * Country *

- V. Medicine/ Vaccine taken/ taking details

- VI. Upload relevant document

All fields marked with an asterisk * are mandatory

II. Patient details: Are you patient? No, date of birth/Age DOB, How do you know patient? Friend.

II. Patient details

Are you a patient? * Select

Yes No, Somebody else is a patient

First name Select Last name Initials ? *

Date of birth/ Age * Select Date of birth * Select

Gender * Select Weight kg

Address 0/150 Pin code *

District * Select State * Select Country *

How do you know the patient? * Select

Friend

- V. Medicine/ Vaccine taken/ taking details

- VI. Upload relevant document

All fields marked with an asterisk * are mandatory

II. Patient details: Are you patient **No**, Date of birth/Age **Age**, How do you know patient? **Family member**. Family member additional box.

Age: In age there is Decade, Year, Month, Week, Day, Hour this options are available.

II. Patient details

Are you a patient? *

Yes
 No, Somebody else is a patient

First name
Last name
Initials ? *

Date of birth/ Age *
Age *

Gender *
Weight

Address
Pin code *

District *
State *
Country *

How do you know the patient? *
Family member *

- V. Medicine/ Vaccine taken/ taking details

- VI. Upload relevant document

*All fields marked with an asterisk * are mandatory*

Condition of family member: Enter relation of family member, contain letters and spaces, and must not exceed 50 characters length.

II. Patient details: Are you patient **No**, Date of birth/Age **Age**, How do you know patient? **Other**, Other additional box.

II. Patient details

Are you a patient? * Select

Yes No, Somebody else is a patient

First name Last name Initials ? *

Select

Date of birth/ Age * Age *

Gender * Weight

Address 0/150 Pin code *

District * State * Country *

Select

How do you know the patient? * Others *

- V. Medicine/ Vaccine taken/ taking details

- VI. Upload relevant document

*All fields marked with an asterisk * are mandatory*

Age: In age there is Decade, Year, Month, Week, Day, Hour these options are available. **Condition of Others:** Enter others, contain letters and spaces, and must not exceed 50 characters length.

III. Health Details: Write down the reason and select Medicine/Vaccines advised by.

There is Medicine/Vaccine advised by Doctor, Pharmacist, Friends, Relatives, Self (Past disease experienced) or Self (No past disease experienced).

III. Health details

Reason(s) for taking medicine(s)/ vaccine(s) ? * 0/5000

Content

Medicines/ Vaccines advised by * Select any one

Select ▼

Condition of Reasons for taking medicine/vaccine: Enter reason(s) for taking medicine(s)/ vaccine(s), contain letters, numbers, spaces and special characters (./() -), and must not exceed 5000 characters length.

IV. Side effect details: Still continuing? Yes.

Write started date of side effect and describe the details of side effect and what treatments were taken to manage the side effect.

IV. Side effect details

Started date *	Still continuing?
<input type="text" value="Select"/>	<input type="text" value="Yes"/>

Describe the details of side effect and what treatments were taken to manage the side effect * 0/5000

Content

Condition for Describe the details of side effect and what treatments were taken to manage the side effect: Contain letters, numbers, spaces and special characters (./()~), and must not exceed 5000 characters length.

IV. Side effect details: Still continuing? No, Stopped date additional box.

IV. Side effect details

Started date *	Still continuing?	Stopped date *
Select	No	Select

Describe the details of side effect and what treatments were taken to manage the side effect * 0/5000

Content

Condition for Describe the details of side effect and what treatments were taken to manage the side effect: Contain letters, numbers, spaces and special characters (./() -), and must not exceed 5000 characters length.

V. Medicine/Vaccine taken/taking details: Write all details of Medicine/Vaccine. Click on **Add**, It added the details.

In dosage form there are Tablet, Capsule, Injection, Oral liquids, Others can select any one. In this section write down Medicine/vaccine name, Manufacturer name, Manufacturing license no., Batch/Lot no., Expiry date, Quantity taken, Started taking date, Stopped taking date.

V. Medicine/ Vaccine taken/ taking details

Blank **Add** *Click here*

Medicine/ Vaccine name *

Manufacturer name **Manufacturing license no. ?**

Batch/ Lot no. ? **Expiry date**


Quantity taken ? * **Dosage form**

Started taking date * **Stopped taking date**

V. Medicine/Vaccine taken/taking details: After click on **Add**. It add medicine vaccine details with medicine vaccine name.

V. Medicine/ Vaccine taken/ taking details

Added detail with Medicine Vaccine name



Medicine/ Vaccine name *

Manufacturer name Manufacturing license no. ?

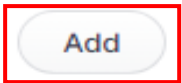
Batch/ Lot no. ? Expiry date

Quantity taken ? * Dosage form

Started taking date * Stopped taking date

V. Medicine/Vaccine taken/taking details: Click on **Add**. It give blank Medicine/Vaccine taken/taking details form.

V. Medicine/ Vaccine taken/ taking details

 **Add** Click here

Medicine/ Vaccine name *

Manufacturer name

Manufacturing license no. ?

Batch/ Lot no. ?

Expiry date

Quantity taken ? *

Dosage form

Started taking date *

Stopped taking date

V. Medicine/ Vaccine taken/ taking details

tttt

Blank  

Blank medicine/vaccine form can delete

Blank medicine/vaccine taken/taking details form

Medicine/ Vaccine name *

Medicine/ Vaccine name

Manufacturer name

Manufacturer name

Manufacturing license no.

Manufacturing licence no.

Batch/ Lot no.

Batch/ Lot no.

Expiry date

Select month & year

Quantity taken *

Quantity taken

Dosage form

Select

Started taking date *

Select

Stoppedtaking date

Select

VI. Upload relevant document: Upload side effect report related document.

Write document title and upload the document if available.

VI. Upload relevant document

Document title Upload document

Document title

📎 Add File

Select and upload file

Submit

Step 2: Click on **Submit**. Window of Mobile Verification will open and message will appear no this.

VI. Upload relevant document

Document title	Upload document
<input type="text" value="Document title"/>	<input type="button" value="Add File"/>

Click Here

Mobile Verification window

ADRMS - Indian Pharmacopoeia Commission

Unregistered Consumer

Home

✓ Submitted successfully

Message

Language option ▾

Medicine/ Vaccine side effect report

Mobile Verification

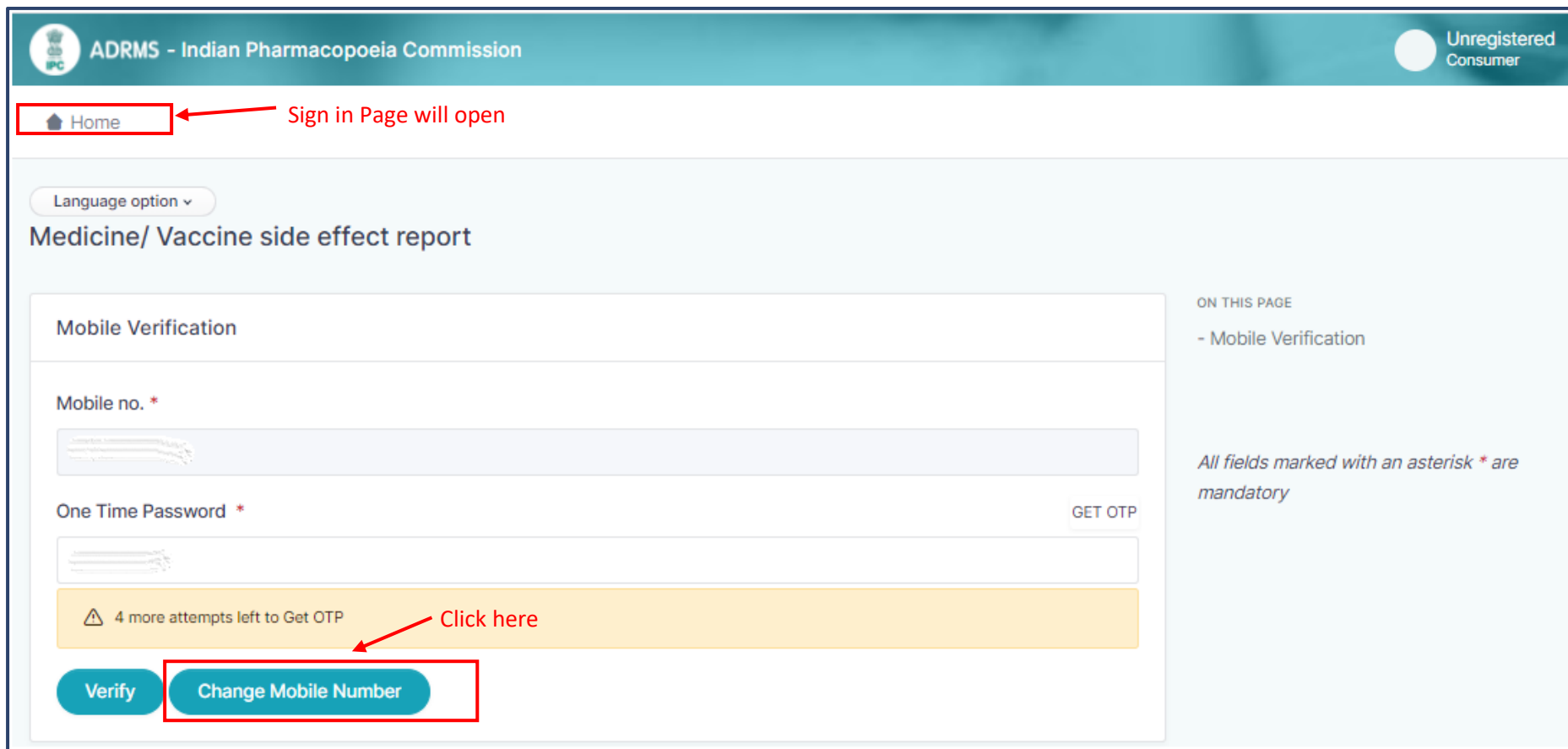
Mobile no. *

One Time Password * GET OTP

ON THIS PAGE
- Mobile Verification

*All fields marked with an asterisk * are mandatory*

Step 3: Enter Mobile no. and OTP. Click on **Change Mobile Number**. Mobile Verification window will open.



ADRMS - Indian Pharmacopoeia Commission

Unregistered Consumer

Home ← Sign in Page will open

Language option ▾

Medicine/ Vaccine side effect report

Mobile Verification

Mobile no. *

One Time Password * GET OTP

⚠ 4 more attempts left to Get OTP Click here

Verify **Change Mobile Number**

ON THIS PAGE
- Mobile Verification

All fields marked with an asterisk * are mandatory

Mobile Verification window

ADRMS - Indian Pharmacopoeia Commission

Unregistered Consumer

Home

Language option ▾

Medicine/ Vaccine side effect report

Mobile Verification

Mobile no. *

One Time Password *

ON THIS PAGE
- Mobile Verification

All fields marked with an asterisk * are mandatory

This is simple three step to fill Medicine/Vaccine side effect report for Unregister Consumer.

Following Table for Medicine/Vaccine side effect report field list:

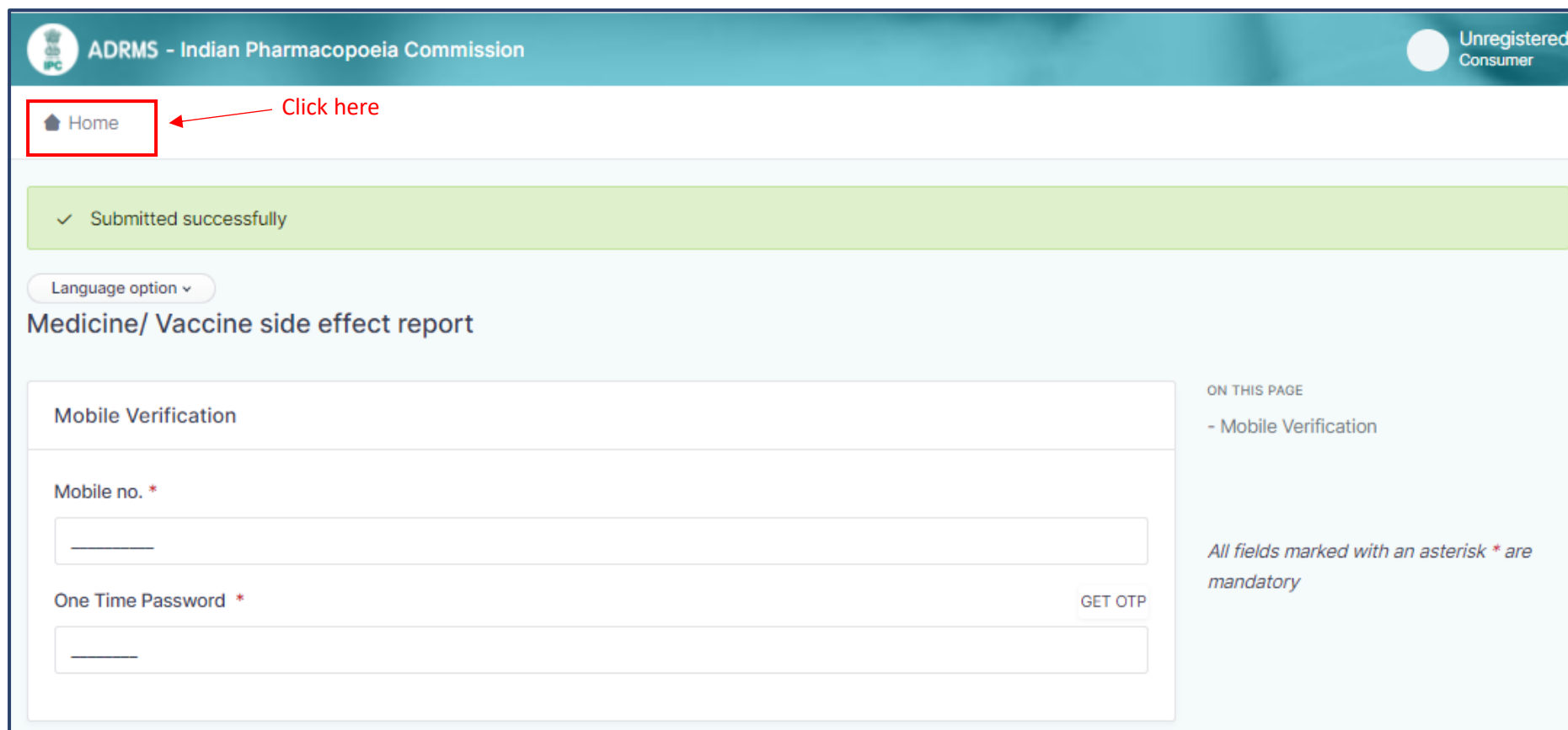
Serial no.	Field name	Purpose	Is field required
I. Initial details			
1	Is this a serious case?	Select Yes or No	Yes:required
2	Seriousness reason	Select reasons(can select more than one)	Yes:required
II. Patient details			
3	Are you a patient?	Select Yes or No	Yes:required
4	First name	First name of patient	Yes:required
5	Last name	Last name of patient	Yes:required
6	Initials	First & Last name initials	Yes:required
7	Date of birth	Select date from calender	Yes:required
8	Age	Select age unit and enter age	Yes:required
9	Gender	Select gender	Yes:required
10	Weight	Enter in Kg	No:Not required
11	How do you know the patient?	Select one Family member, Friend, Other	Yes:required
12	Family member	Write what relationship with patient	Yes:required
13	Others	Write other relationship with patient	Yes:required
III. Health details			
14	Reason(s) for taking medicine(s)/ vaccine(s)	Enter Reason within 5000 char length	Yes:required
15	Medicines/ Vaccines advised by	Select one who advise Medicine/Vaccine	Yes:required
IV. Side effect details			
16	Started date	Select started date of side effect	Yes:required
17	Still continuing?	Select Yes or No	No:Not required

18	Stopped date	Enter stopped date of side effect	Yes:required
19	Describe the details of side effect	Describe the side effect	Yes:required
V.Medicine/Vaccine taken/taking details			
20	Medicine/ Vaccine name	Medicine/Vaccine name within 100 char length	Yes:required
21	Manufacturer name	Manufacturer name of medicine/Vaccine	No:Not required
22	Manufacturing license no.	Manufacturing license no. of Medicine/Vaccine	No:Not required
23	Batch/ Lot no.	Batch/Lot no. of Medicine/Vaccine	No:Not required
24	Expiry date	Select expiry date of Medicine/Vaccine	No:Not required
25	Quantity taken	write how much no. of medicine taken/taking	Yes:required
26	Dosage form	Select one dose form like tablet,injection etc	No:Not required
27	Other	Write other dosage form if taken/taking	Yes:required
28	Started taking date	Select Medicine/Vaccine started date	Yes:required
29	Stopped taking date	Select Medicine/Vaccine stopped date	No:Not required
VI.Upload relevant document			
30	Document title	Enter Uploading document name	No:Not required
31	Upload document	Doc format is JPG/PDF/MP4 & Max size:10MB	No:Not required

Table2: Medicine/Vaccine side effect report field list

2. How go to ADRMS Home page or Sign In page

Step 1: Click on **Home** sign. Another window of ADRMs home or sign in page will open.



The screenshot shows the ADRMS - Indian Pharmacopoeia Commission website. The header includes the logo and the text "ADRMS - Indian Pharmacopoeia Commission" on the left, and "Unregistered Consumer" on the right. A navigation bar contains a "Home" button with a house icon, which is highlighted with a red box. A red arrow points to this button with the text "Click here". Below the navigation bar, a green banner displays "Submitted successfully". A "Language option" dropdown menu is visible. The main heading is "Medicine/ Vaccine side effect report". The primary content area is titled "Mobile Verification" and contains two input fields: "Mobile no. *" and "One Time Password *". A "GET OTP" button is located to the right of the One Time Password field. On the right side of the page, there is a section titled "ON THIS PAGE" with the sub-heading "- Mobile Verification" and a note: "All fields marked with an asterisk * are mandatory".

Sign in page

ADRMS

Stepping towards patient's safety

An Indigenous Adverse Drug Reactions Monitoring System (ADRMS) by Indian Pharmacopoeia Commission (IPC), Ministry of Health & Family Welfare, Govt. of India, to ease reporting and monitoring of adverse events (side effects) on patients due to medical products (medicine, vaccine & medical device) for the safety of patients.

Designed, Developed & Maintained by C-DAC .

Sign in

Username/ Mobile no.

Password [I forgot password](#)

Remember me on this device

[Sign in](#)

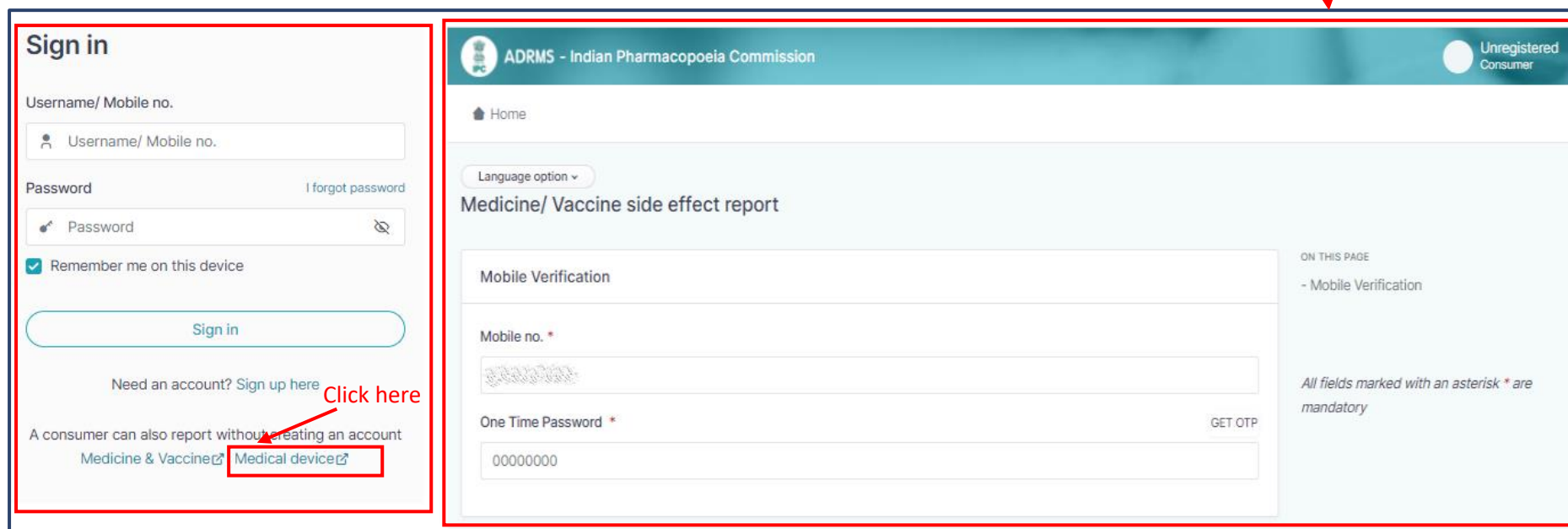
[Need an account? Sign up here](#)

A consumer can also report without creating an account
[Medicine & Vaccine](#) [Medical device](#)

3. How Submit Medical Device side effect report

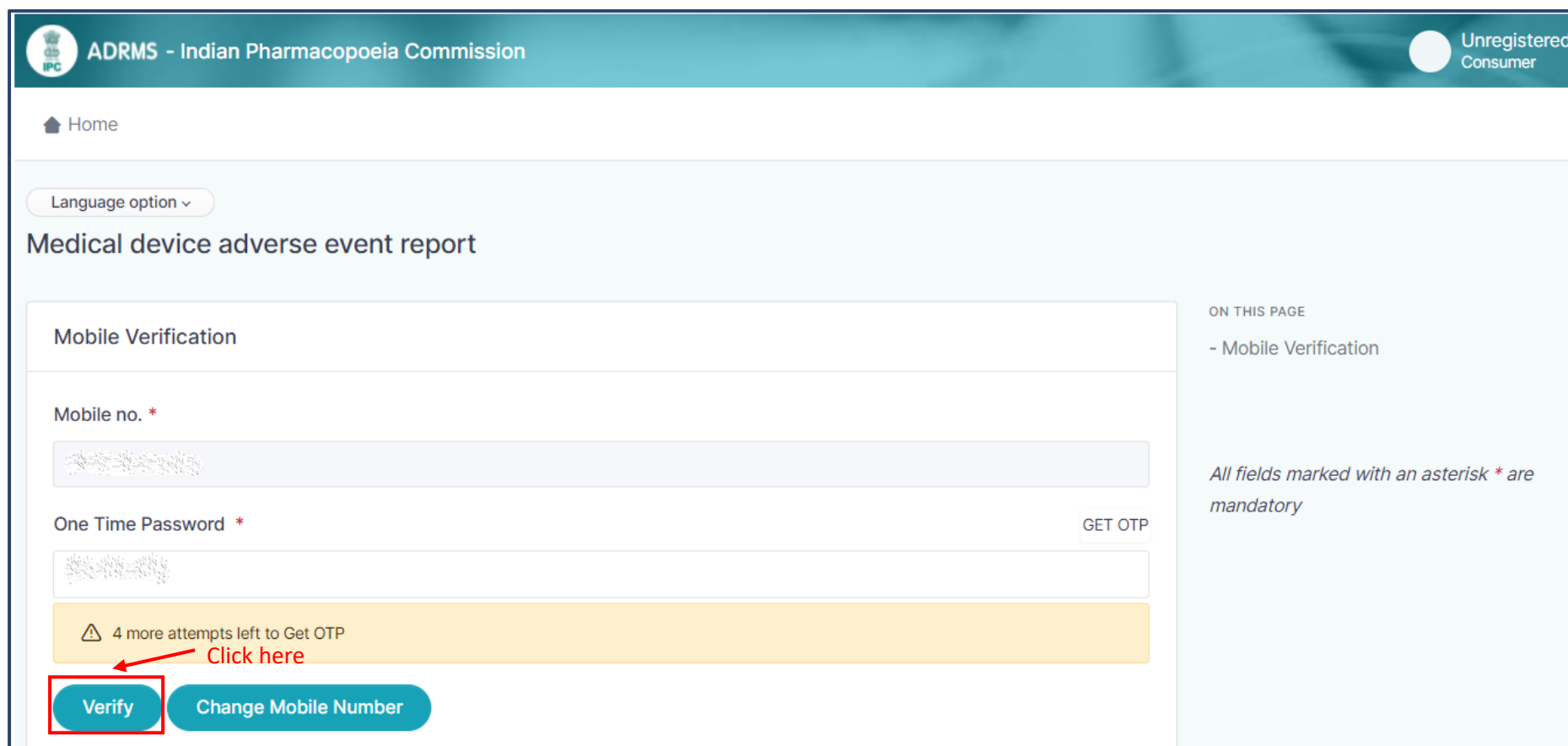
Step 1: Click on **Medical device**. Mobile Verification window will appear.

Mobile verification window



The screenshot displays the ADRMS - Indian Pharmacopoeia Commission website. On the left, a 'Sign in' panel contains fields for 'Username/ Mobile no.' and 'Password', a 'Remember me on this device' checkbox, and a 'Sign in' button. Below these fields, a link for 'Sign up here' is present, with a red arrow pointing to it and the text 'Click here'. At the bottom of the sign-in panel, there are two links: 'Medicine & Vaccines' and 'Medical device', with a red box around the latter. The main content area on the right features a teal header with the site name and 'Unregistered Consumer' status. Below the header, there is a 'Home' button and a 'Language option' dropdown. The main heading is 'Medicine/ Vaccine side effect report'. A 'Mobile Verification' section contains a 'Mobile no. *' field with a masked number, a 'One Time Password *' field with the number '00000000', and a 'GET OTP' button. A sidebar on the right indicates 'ON THIS PAGE - Mobile Verification' and a note that 'All fields marked with an asterisk * are mandatory'. A red arrow from the text 'Mobile verification window' points to the 'Mobile Verification' section.

Step 2: Enter Mobile no. and OTP. Click on **Verify**. Medicine/Vaccine side effect report will open.



ADRMS - Indian Pharmacopoeia Commission

Unregistered Consumer

Home

Language option ▾

Medical device adverse event report

Mobile Verification

Mobile no. *

One Time Password * GET OTP

⚠ 4 more attempts left to Get OTP [Click here](#)

Verify Change Mobile Number

ON THIS PAGE
- Mobile Verification

All fields marked with an asterisk * are mandatory

Following Table for Mobile verification of Medical device side effect report field list:

Serial no.	Field name	Purpose	Is field required
1	Mobile no.	Valid 10 digit mobile no.	Yes:required
2	One Time Password	8 digit OTP on mobile number	Yes:required

Table3: Mobile verification of Medical device side effect report field list

In report there are patient details, Adverse details, Medical device details, Upload relevant document these 4 sections are present.

I. Patient details

II. Adverse details


III. Medical device details

IV. Upload relevant document (these all are link to jump on particular section)


*All fields marked with an asterisk * are mandatory.*

English, Hindi two language are available. Home sign for redirect to home page of consumer.

I. Patient details: Are you patient? Yes.



ADRMS - Indian Pharmacopoeia Commission



Unregistered Consumer

Home

Language option

Medical device adverse event report

I. Patient details

Are you a patient? *

Yes No, Somebody else is a patient

First name

Select

Last name

Auto created

Initials ? *

Date of birth/ Age *

Gender *

Weight

kg

Address

0/150

Pin code *

District *

State *

Country *

ON THIS PAGE

- I. Patient details
- II. Adverse event details
- III. Medical device details
- IV. Upload relevant document

All fields marked with an asterisk * are mandatory

I. Patient details: Are you a patient? **No**. How do you know the patient? **Friend**.

Select are you patient? or not, write First name, Last name, Initials is auto generated, DOB/Age, select Gender(in Female, Male, Transgender) and select How do you know patient.

Medical device adverse event report

I. Patient details

Are you a patient? *

Yes No, Somebody else is a patient ← Click here

First name Last name Initials ? *

Date of birth/ Age * Gender *

Weight kg

How do you know the patient? * ← Select

ON THIS PAGE

- I. Patient details
- II. Adverse event details
- III. Medical device details
- IV. Upload relevant document

All fields marked with an asterisk * are mandatory

I. Patient details: Are you a patient? **No**, Date of birth/Age **DOB**, How do you know the patient? **Family Member**.

Select are you patient? or not, write First name, Last name, Initials is auto generated, DOB/Age select, select Gender(in Female, Male, Transgender) and select How do you know patient family member. If patient is family member then additional box for family member.

I. Patient details

Are you a patient? *

Yes
 No, Somebody else is a patient
← Click here

First name
Last name
Initials ? *

Date of birth/ Age *
Date of birth *
Gender *

Weight

← Select

How do you know the patient? *
Family member *
← Select

ON THIS PAGE

- I. Patient details
- II. Adverse event details
- III. Medical device details
- IV. Upload relevant document

All fields marked with an asterisk * are mandatory

I. Patient details: Are you a patient? **No**, Date of birth/Age **age**, How do you know the patient? **Other**.

Select are you patient? or not, write First name, Last name, Initials is auto generated, DOB/Age select **Age** and this age have **Decade, Year, Month, Week, Day, Hour** options. Select Gender (options are Female, Male, and Transgender) and select How do you know patient?.

I. Patient details

Are you a patient? *

Yes
 No, Somebody else is a patient
← Click here

First name
 Last name
 Initials

Date of birth/ Age *
 Age *
 Gender *

Weight

How do you know the patient? *
 Others *

ON THIS PAGE

- I. Patient details
- II. Adverse event details
- III. Medical device details
- IV. Upload relevant document

All fields marked with an asterisk * are mandatory

II. Adverse event details: Location of event **Home**, Device operator **Physician**, Was device return to local supplier **No**.

Select Date of event, Location of event, Describe the details of adverse event, Device operator is Physician .Device operator have four options (Physician, Patient, Other, None or problem prior notice to us). Device operator is Physician, Patient, None or problem prior notice to us. Select Was device return to local supplier, Write other relevant information.

II. Adverse event details

Date of event *

Location of event

← Select

Describe the details of adverse event * 0/5000

Content

Device operator

← Select any 1 (Physician, Patient, None or problem prior notice to us)

Was device return to local supplier

← Select

Other relevant information 0/2500

Content

All fields marked with an asterisk * are mandatory

Condition Describe the details of adverse event: Please describe the details of side effect, contain letters, numbers, spaces and special characters (./()-), and must not exceed 5000 characters length.

II. Adverse event details: Location of event **Hospital**, Device operator **Other**, Was device return to local supplier **Yes**.

II. Adverse event details

Date of event *

Location of event Select

IPD/ OPD *

Hospital name *

Hospital address * 0/150

Describe the details of adverse event * 0/5000

Device operator Select

Others *

Was device return to local supplier Select

Date of return *

Specify location *

Other relevant information 0/2500

ON THIS PAGE

- I. Patient details
- II. Adverse event details
- III. Medical device details
- IV. Upload relevant document

*All fields marked with an asterisk * are mandatory*

If Location of event is Hospital then IPD/OPD, Hospital name, Hospital address this information is write down. If Other is Device operator then additional box for Other. Was device return to local supplier is Yes then write Date of return. In IPD/OPD IPD, OPD, CR these three option are available.

Condition Describe the details of adverse event: Please describe the details of side effect, contain letters, numbers, spaces and special characters (./()-), and must not exceed 5000 characters length.

II. Adverse event details: Location of event **Other**, Device operator **Other**, Was device return to local supplier **Yes**.

II. Adverse event details

Date of event * Location of event Select

Others *

Describe the details of adverse event * 0/5000

Device operator Others * Select

Was device return to local supplier Date of return * Select

Specify location *

Other relevant information 0/2500

- III. Medical device details
- IV. Upload relevant document

*All fields marked with an asterisk * are mandatory*

Location of event is Other then additional box for Other is there.

III. Medical device details: Write all Medical device details.

Write Device name, Model no., Serial no., Batch/Lot no., Software version, Manufacture/Installation date, Expiry date, Implantation date, Device manufacturer name and Local supplier name.

III. Medical device details

Device name *

Model no.

Serial no.

Batch/ Lot no.

Software version

Manufacture/ Installation date

Expiry date

Implantation date

Device manufacturer name

Local supplier name

- I. Patient details
- II. Adverse event details
- III. Medical device details
- IV. Upload relevant document

All fields marked with an asterisk * are mandatory

Device Name: Please enter device name, contain letters, numbers, spaces and special characters (./() -), and must not exceed 100 characters length.

IV. Upload relevant document: Upload document with title.

If any document available then upload and write document title.

IV. Upload relevant document

Document title	Upload document
<input type="text" value="Document title"/>	<input type="button" value="Add File"/>

Upload file here

Designed, Developed & Maintained by C-DAC .

Step 2: Click on **Submit**. Window of Mobile Verification will open and message will appear no this.

VI. Upload relevant document

Document title	Upload document
<input type="text" value="Document title"/>	<input type="button" value="Add File"/>

Click Here

Mobile Verification window

ADRMS - Indian Pharmacopoeia Commission

Unregistered Consumer

Home

✓ Submitted successfully

Message

Language option ▾

Medical device adverse event report

Mobile Verification

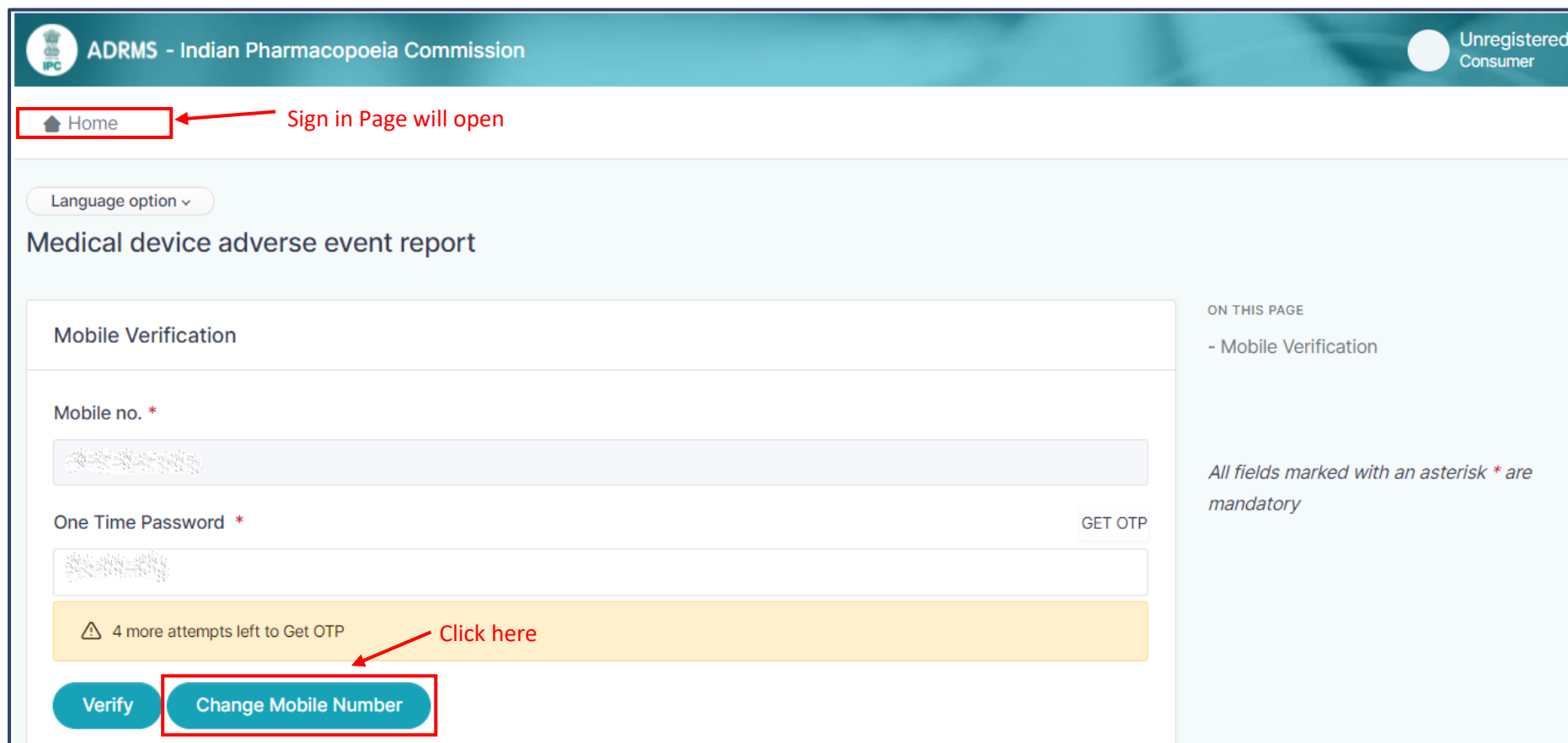
Mobile no. *

One Time Password * GET OTP

ON THIS PAGE
- Mobile Verification

All fields marked with an asterisk * are mandatory

Step 3: Enter Mobile no. and OTP. Click on **Change Mobile Number**. Mobile Verification window will open.



ADRMS - Indian Pharmacopoeia Commission

Unregistered Consumer

Home

Language option v

Medical device adverse event report

Mobile Verification

Mobile no. *

One Time Password * GET OTP


4 more attempts left to Get OTP

Verify Change Mobile Number

ON THIS PAGE
- Mobile Verification

All fields marked with an asterisk * are mandatory

Mobile Verification window



ADRMS - Indian Pharmacopoeia Commission

Unregistered Consumer

Home

Language option ▾

Medical device adverse event report

Mobile Verification

Mobile no. *

One Time Password *

GET OTP

ON THIS PAGE

- Mobile Verification

*All fields marked with an asterisk * are mandatory*

This is simple three step to fill Medical device side effect report for Unregister Consumer.

Following Table for Medical device side effect report field list:

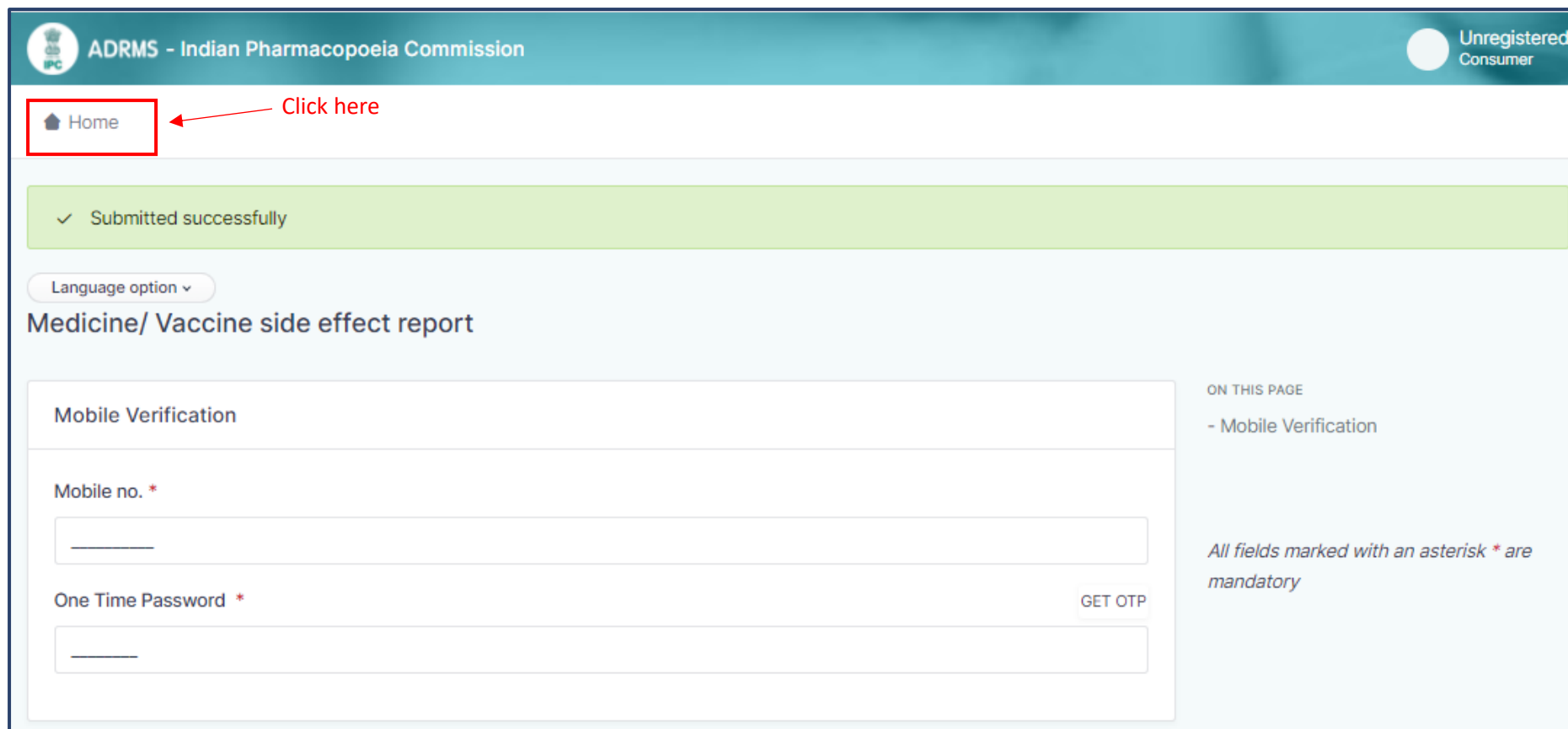
Serial no.	Field name	Purpose	Is field required
I.Patient details			
1	Are you a patient?	Select Yes or No	Yes:required
2	First name	First name of patient	Yes:required
3	Last name	Last name of patient	Yes:required
4	Initials	First & Last name initials	Yes:required
5	Date of birth	Select date from calender	Yes:required
6	Age	Select age unit and enter age	Yes:required
7	Gender	Select gender	Yes:required
8	Weight	Enter in Kg	No:Not required
9	How do you know the patient?	Select one Family member, Friend, Other	Yes:required
10	Family member	Write what relationship with patient	Yes:required
11	Others	Write other relationship with patient	Yes:required
II.Adverse event details			
12	Date of event	Select date	Yes:required
13	Location of event	Select one location Home, Hospital, Other	No:Not required
14	Describe the details of adverse event	describe the details within 5000 char length	Yes:required
15	Device operator	Select who is operator ex. Physician, Patient etc	No:Not required
16	Was device return to local supplier	Select Yes or No	No:Not required
17	Other relevant information	Write within 2500 char	No:Not required
III.Medical device details			
18	Device name	Write within 100 char length	Yes:required

19	Model no.	Write Model no. of device	No:Not required
20	Serial no.	Write serial no. of device	No:Not required
21	Batch\Lot no.	Write batch/lot no of device	No:Not required
22	Software version	Write software version of device	No:Not required
23	Manufacture/ Installation date	Select Manufacture date of device	No:Not required
24	Expiry date	Select expiry date of device	No:Not required
25	Implantation date	Select implantation date of device	No:Not required
26	Device manufacturer name	Write manufacturer name	No:Not required
27	Local supplier name	Write supplier name	No:Not required
IV.Upload relevant document			
28	Document title	Enter Uploading document name	No:Not required
29	Upload document	Doc format is JPG/PDF/MP4 & Max size:10MB	No:Not required

Table4: Medical device side effect report field list


How go to ADRMS Home page or Sign In page

Step 1: Click on **Home sign**. Another window of ADRMs home or sign in page will open.



The screenshot shows the ADRMS - Indian Pharmacopoeia Commission website. At the top left, there is a logo and the text "ADRMS - Indian Pharmacopoeia Commission". At the top right, there is a circular icon and the text "Unregistered Consumer". Below the header, there is a navigation bar with a "Home" button highlighted by a red box. A red arrow points to the "Home" button with the text "Click here". Below the navigation bar, there is a green banner with a checkmark and the text "Submitted successfully". Below the banner, there is a "Language option" dropdown menu. The main content area is titled "Medicine/ Vaccine side effect report". On the left side, there is a "Mobile Verification" section with two input fields: "Mobile no. *" and "One Time Password *". A "GET OTP" button is located to the right of the "One Time Password" field. On the right side, there is a section titled "ON THIS PAGE" with the text "- Mobile Verification". Below this, there is a note: "All fields marked with an asterisk * are mandatory".

Sign in page

 **ADRMS**

Stepping towards patient's safety

An Indigenous Adverse Drug Reactions Monitoring System (ADRMS) by Indian Pharmacopoeia Commission (IPC), Ministry of Health & Family Welfare, Govt. of India, to ease reporting and monitoring of adverse events (side effects) on patients due to medical products (medicine, vaccine & medical device) for the safety of patients.

■ *Designed, Developed & Maintained by C-DAC*

Sign in

Username/ Mobile no.

Password [I forgot password](#)

Remember me on this device

[Sign in](#)

[Need an account? Sign up here](#)

A consumer can also report without creating an account
[Medicine & Vaccine](#) [Medical device](#)

