Country	El Salvador
Language	Español
Reporter Type Title	Health Care Professional / HCP Staff

Selected Case Types

AE	☒
MIR	☐
PQC	☐
Managed Access	☐

Patient

Salutation	
First Name	
Last Name	
Consent To Contact Reporter	☐
Email Address	
Phone Number	
Autonomous Community	
Program Number	
Patient Enrollment ID	

Address

Mailing Address Line1	
Country	El Salvador
City	
Zip Code	
State	
Initials	
Date of Birth	2025-05-15
Age	

Age Group	
Gender	Femenino
Ethnicity	Desconocido
Imperial Height ft	
Imperial Height in	
Imperial Weight lb	
Metric Height cm	165
Metric Weight kg	200
Military Status	
Is Pregnant	☐
Details Of Previous Pregnancy	
Medical History	

HCP

Medical Officer Occupation	Enfermera registrada
Non MOW Specialty	Oncología

Medical Officer Name

Salutation	
First Name	
Last Name	
HCPID	

HCP Name

Salutation	Srta.
First Name	********
Last Name	********

Address

Mailing Address Line1	********
Country	El Salvador
City	********
State	No aplicable
Zip Code	********
HCP Occupation	
Specialty	
Consent To Contact HCP	☒
Email Address	********
Phone Number	********
Autonomous Community	
Phone Number Extn	
Fax Number	
Institution Name	********
HCP Department	

Caregiver

Salutation	
First Name	
Last Name	
Relation Ship To Patient	
Consent To Contact	☐
Email Address	
Phone Number	
Autonomous Community	

Address

Mailing Address Line1	
Country	El Salvador
City	
State	
Zip Code	

AE Form Details

Products

Medication/Device	Lynparza
Batch Lot No	Desconocido
Why Is This Med Taken	CANCER DE MAMA
How Is This Med Taken	Oral
Dose	150
Unit	mg
Frequency	2 veces al día
Action Taken	Desconocido
Start Date	
End Date	
Expiration Date	
Unique Device ID	
Operator Of Device	Paciente/cuidador
Operator Other Text	

Vaccination Details

How many doses of this vaccine have you (or the patient) received?	

Dose 1

Batch / Lot Number	
Expiration Date	
Manufacturer Name	
Date Given	
Action Taken	

Event

What Is Your Event	NAUSEAS
When did it start	
When did it stop	
Duration	
Event Outcome	Recuperado
Date of Death	

Autopsy Performed	☐
Autopsy confirmed this event as cause of Death	☐
Is Death	☐
Is Life Threatening	☐
Is Congenital Anomaly	☐
Is Hospitalisation	☐
Is Disability	☐
Is Important Medical Event	☒
Device Only Required Intervention	☐

Hospital

Hospitalisation Date	
Discharge Date	

Products	Events	Does the reporter believe the medication caused the event	Did Symptoms Improve	Was Medication Restarted	Did Event Reappear
Lynparza	NAUSEAS	Yes			

Any Additional Info

By ticking this box, I confirm that the information I've provided is accurate and complete to the best of my knowledge. ☐

Note: Date field format is yyyy-mm-dd