Ohio Vision Professionals Board

DRUG-INDUCED SIDE EFFECTS REPORT

Every optometrist, in accordance to Rule 4725-5-14, shall complete this report form and return it to the board office within ten (10) days of the receipt of the form by the reporting optometrist. Neither the report, nor any added information provided by the optometrist, will include the name or other specific identifying information on the patient. This report is to include detailed information on the reaction, action taken by the attending optometrist, and outcome of the incident in relation to patient's final condition.

PLEASE TYPE OR LEGIBLY PRINT IN INK

1. Name of Optometrist:	Telephone Number:
2. Optometry License Number:	Therapeutic Certificate Number:
3. Office Address (street/city/state/zip):	
4. Patient: (Please do not include patient name) Sex: Male or Female	Age:
5. Complete Description of Drug Reaction or Side Effect:	
6. Date of Drug Reaction Onset: Time Between Administration and Onset: ☐ Physical ☐ Psychological	
7. Suspect Drug(s) Trade/Generic Name: Lot Number:	Expiration Date:

77 South High Street, 16th Floor
Columbus, Ohio 43215-6108 U.S.A.
board@vision.ohio.gov

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614 | 995-5392 fax
www.vision.ohio.gov

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8. Disorder or Reason for Use of Drugs: (Define Presenting Problem)

☐ Diagnostic ☐ Therapy

9. Method of Administration:

☐ Topical ☐ Oral

By whom:____

☐ In office use

☐ Pharmacy dispensed

☐ Dispensed by optometrist and taken out of office

10. Other Drug(s) Taken Concomitantly:

11. Subsequent Action Taken: (Including Follow Up)

Signature of Optometrist: Date:

Printed Name:

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