

## Sample Information Form

Thank you for entrusting your drug or dietary supplement analysis to [www.pharmanalyze.com](http://www.pharmanalyze.com). Your medication will be analyzed in our laboratory by pharmaceutical analysis experts.

**The sample to be analyzed must be accompanied by this completed form**, so that we have all the necessary information.

### ⇒ Order information

Order reference	
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### ⇒ General information about the sample

Sample type	<input type="checkbox"/> Medicine / Drug <input type="checkbox"/> Dietary supplement
Trade name	
Generic name / International Common Name	
Name of active ingredients	
Dosage of active ingredients (mg, mcg (microgramme), % or other unit)	
Pharmaceutical form	<input type="checkbox"/> Tablet <input type="checkbox"/> capsule <input type="checkbox"/> Liquid <input type="checkbox"/> Powder <input type="checkbox"/> Other (please specify):
Physical aspect	Color: Size: Marking (number, logo, letter): Odor (if applicable): Taste (if applicable):
Manufacturer's name	
Batch number	
Date of manufacture	
Expiry date	

## ⇒ Origine du médicament

Date of purchase	
Place of purchase	<input type="checkbox"/> Pharmacy (place) <input type="checkbox"/> Online pharmacy website name : _____ <input type="checkbox"/> Market / Informal sales <input type="checkbox"/> Other (please specify):
Country of origin (according to packaging)	
Supplier (if different from manufacturer)	

## ⇒ Packaging and traceability information

Presence of original packaging	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Type of packaging	<input type="checkbox"/> Cardboard box <input type="checkbox"/> Vial <input type="checkbox"/> Other (please specify):	<input type="checkbox"/> Blister <input type="checkbox"/> Sachet
Barcode	<input type="checkbox"/> Yes	<input type="checkbox"/> No
QR Traceability Code	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Presence of patient's leaflet	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Leaflet language(s)		
Visibles anomalies	<input type="checkbox"/> Spelling errors <input type="checkbox"/> Typographic differences <input type="checkbox"/> Impaired sealing <input type="checkbox"/> Other (please specify):	

## ⇒ Usage history

Has the drug already been used by a patient?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If Yes	Réactions ou effets secondaires observés (préciser) _____ Différences perçues par rapport à des lots précédents : _____	

⇒ **Reasons for analysis**

Suspected counterfeiting	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Efficiency anomalies	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Physical abnormalities (appearance, smell, texture)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Standard verification request	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other reasons (please specify)		

⇒ **Additional information (Optional)**

Applicant's occupation	<input type="checkbox"/> Individual <input type="checkbox"/> Healthcare professional <input type="checkbox"/> Pharmaceutical industry <input type="checkbox"/> Other (please specify):
Additional comments or observations	