|  |  |
| --- | --- |
| Date received:  (DD/MM/YY) |  |
| Inquiry received by: |  |
| Inquiry receipt way:  (E.g. phone, email, etc.) |  |

|  |  |
| --- | --- |
| Inquirer:  (please mark it with X) | Health Professional (HCP) \_ Patient \_ |
| If HCP:  (please mark it with X) | Doctor \_ Pharmacist \_ Other (please specify): |
| Title: |  |
| Name: |  |
| Telephone number: |  |
| Email address: |  |
| Institution  (if applicable) |  |

|  |  |
| --- | --- |
| Product name: |  |

|  |  |
| --- | --- |
| Medical Inquiry details: |  |

**Please forward the filled form immediately, but no later than 48 hours to** [**safety@xellia.com**](mailto:safety@xellia.com) **or medical@xellia.com.**