|  |  |
| --- | --- |
| 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** **or medical@xellia.com.**