

Date received:

AEFI Advisory Committee Category:

**ADVERSE EVENT FOLLOWING IMMUNISATION**

<b>Case Identification</b>				Unique No:			
Name				Gender			
Surname		Given Name		Medicare No.		Ref no.	
<b>Parent/Carer Details</b>							
Address							
Suburb		Postcode		Phone			
Date of Birth		If Unknown		Age		Occupation/Workplace	
Aboriginal or Torres Strait Islander		Yes		No		Unknown	
Country Of Birth				Other (specify)			
Language Spoken At Home				Other (specify)			
HNE Staff Member		Yes		No			
If yes, workplace				Work Phone No.			
<b>Source Of Report</b>							
No. in order of reporting:		Hospital		Doctor		Self/Parent/Guardian	
Name		Phone		Date reported			
Name of treating medical officer				Phone			
OK to talk to case/parent?		yes		No			
<b>Clinical details</b>							
Onset date and time adverse event began		Date		Time			
How long after vaccination did the event occur?		minutes		hours		days	
<b>Description of event (giving timing of events)</b>							

Record all vaccines given within 30 days prior to adverse event

Type of vaccine (DTP, Hib, OPV, MMR, etc.)	Brand name (Manufacturer)	Dose No.	Date given (time if known)	Batch Number	Clinic/GP Postcode

In the GPs opinion which vaccine is considered the cause?

Why? (eg. vaccine storage/transport affecting cold chain, incorrect vaccination technique, manufacturer error, vaccine-associated, etc)

Was paracetamol given just prior to vaccination?                      Yes                      No                      Unknown  
 Was the case unwell at the time of vaccination?                      Yes                      No                      Unknown

If yes, describe symptoms and signs

Previous medical history (where appropriate)  
 Including previous vaccination reactions

Gestational age	/40		Birth weight			grams
Allergies		Yes		No		Unknown
Congenital anomalies		Yes		No		Unknown
Convulsions		Yes		No		Unknown
Epilepsy		Yes		No		Unknown
Other neurological disorders		Yes		No		Unknown
Other conditions						
If yes to any of above, please describe						
Was medical advice sought?			Yes			No
Doctor's name			Phone			
Was the case hospitalized?			Yes		No	
If yes,	Admission Date		Discharge Date		Hospital	
MRN	VMO	Registrar		Page		
Has the case recovered?			Yes			No
If yes, date recovered						
How long after the onset did the case recover?			minutes/hours/days			
If, no, describe condition now: -						
If died, DOD		Cause of death				
Type of Adverse Event eg. anaphylaxis, flat/floppy, severe local reaction						
Category (Public Health Unit to complete):		unclear	possible	probable	certain	
<b>Follow-Up Management</b>						
Was the recommended vaccination schedule altered?			Yes	No	Unknown	
If yes, what has been suggested						

Administration of initial report  
 Completed  
 by

Date  
 :