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| Department of Health  Communicable Diseases Prevention Unit  Immunisation section | C:\Documents and Settings\tstewart\Desktop\100079-Tas-Gov_no-tag_rgb_hor.jpg |

**Adverse Event Following Immunisation (AEFI)**

**Reporting Form**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| IMMUNISATION SECTION OFFICE USE ONLY | | | | | | | | | | | | | Initial report  Amendment  Nullification | | | | | | | | | | | | | | |
| Date 1st Received:  ……/……. /…… | | | | Event ID: | | | Date Update Received:  ……./……/…… | | | | | | | | Sender Case Reference: | | | | | | | | | | | | |
| **Vaccinated Person Details** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First Name: | | | | | | | | Surname: | | | | | | | | | | | | | DOB:      /     / | | | | | | |
| Address: | | | | | | | | Suburb: | | | | | | | | | | | | | Postcode: | | | | | | |
| Email: | | | | | | | | Mobile: | | | | | | | Gender:  Male  Female  Other | | | | | | | | | | | | |
| Indigenous status:  Aboriginal  Torres Strait Islander  Both Aboriginal and Torres Strait Islander  Neither | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Parent/Guardian Details (if applicable)** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First Name: | | | | | | | | | | Surname: | | | | | | | | | | | | | | | | | |
| Email: | | | | | | | | | | Mobile: | | | | | | | | | | | | | | | | | |
| **Person Reporting Details** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Report Date:      /     / | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Relationship to Vaccinated Person**: | | | | Self (as above) | | | Parent/Guardian (as above) | | | | | | | | | | | Doctor | | | | | | Nurse/Midwife | | | |
| Other (please specify): | | | | | | | | | | | | | | | | | | | | | | | |
| First Name: | | | | | | | | Surname: | | | | | | | | | Email: | | | | | | | | | | |
| Organisation Name: | | | | | | | | | | | | | | | | | Phone: | | | | | | | | | | |
| **Consent** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **I give consent for the Communicable Diseases Prevention Unit Immunisation Section to:**   * Contact the person reporting the event Yes  No * Contact the immunisation provider listed Yes  No  N/A | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Immunisation Provider Details** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Who provided the vaccine:** | | | | Doctor | | | | Nurse/Midwife | | | | | | Pharmacist | | | | | | | | | | | Unknown | | |
| Other (please specify): | | | | | | | | | | | | | | | | | | | | | | | |
| **Location:** | GP | | | Council | | Aboriginal Health | | | | | | Hospital | | | | School | | | | | | | | State Run Clinic | | | |
| RACF | | | Unknown | | | | Other (please specify): | | | | | | | | | | | | | | | | | | | |
| First Name: | | | | | | | | Surname: | | | | | | | | | | | | | | | | | | Phone: | |
| Address: | | | | | | | | | | | | | Suburb: | | | | | | | | | | | | | Postcode: | |
| **Medical History** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Illness at the time of vaccination? | | | | | | | | | | | | | | | | | | Yes  No  Unknown | | | | | | | | | |
| Received any other vaccine in the last 4 weeks? | | | | | | | | | | | | | | | | | | Yes  No  Unknown | | | | | | | | | |
| Taken any medicines in the last 3 months? | | | | | | | | | | | | | | | | | | Yes  No  Unknown | | | | | | | | | |
| Any important pre-existing medical conditions, including severe allergies? | | | | | | | | | | | | | | | | | | Yes  No  Unknown | | | | | | | | | |
| Pregnant at the time of vaccination?  Yes  No  N/A  Unknown **Gestation** (if known):       weeks | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Only if aged under 2 years:**  Gestation at birth:       weeks Birth weight:       grams | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Details**: *(please complete if ‘yes’ to any of the above)* | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Vaccines Administered** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Tick if you do not know which vaccine was administered, and skip to “Adverse Event Description”** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date of Vaccination:      /     / | | | | | | | | Time of Vaccination:       (24hr clock) | | | | | | | | | | | | | | | | | | | |
| Vaccine Name | | | Dose No. | | Batch Number | | | Route of Administration\* | | | | | | | | | | Site\* | | | | | | | | | |
|  | | |  | |  | | | IM  Oral  SC  ID  Unknown | | | | | | | | | | LA  RA  LL  RL  O  Unknown | | | | | | | | | |
|  | | |  | |  | | | IM  Oral  SC  ID  Unknown | | | | | | | | | | LA  RA  LL  RL  O  Unknown | | | | | | | | | |
|  | | |  | |  | | | IM  Oral  SC  ID  Unknown | | | | | | | | | | LA  RA  LL  RL  O  Unknown | | | | | | | | | |
|  | | |  | |  | | | IM  Oral  SC  ID  Unknown | | | | | | | | | | LA  RA  LL  RL  O  Unknown | | | | | | | | | |
| *\*IM = Intramuscular, SC = Subcutaneous, ID = Intradermal, LA = Left Arm, RA = Right Arm, LL = Left Leg, RL = Right Leg,*  *O = Other Site (please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| If Bexsero vaccine was administered and the child is less than 2 years old, did they receive paracetamol before or at the time of vaccination? | | | | | | | | | | | | | | | | | | | | | | Yes  No  N/A | | | | | |
| If Bexsero vaccine was administered, did the child have the two further recommended doses of paracetamol after vaccination? | | | | | | | | | | | | | | | | | | | | | | Yes  No  N/A | | | | | |
| **Are you completing this form to report a vaccine administration error?**  *If yes, please provide the specific details in the ‘details of event’ box below.* | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | | | |
| **Adverse Event Description** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Onset Date:**      /     /      Onset Time (if known):       (24hr clock) | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Time from vaccination to onset of symptoms:**       days       hours       minutes | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Outcome of event:**  Recovered  Ongoing  Recovered with complications  Fatal  Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Recovery Date (if relevant)**:      /     / | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Details of event**: *(be as descriptive as you can)* | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Treatment Details** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Treatment Type** | | Self (did not seek medical assistance) | | | | | | | | | Helpline | | | | | | | | | Nurse | | | | | | | GP |
| Hospital Emergency | | | | | | | Specialist Outpatient Clinic | | | | | | | | | | | | | | Unknown | | | | |
| Hospital Admission: Number of days Admitted:       Date of discharge:      /     / | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Treatment Received**: | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Organisation Name: | | | | | | | | | | | | | | | | | | | Phone: | | | | | | | | |
| **COVID-19 Check** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Has the vaccinated person **ever** had a COVID-19 infection?  Yes  No  Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| If yes, the last known date of infection is      /     /      **OR**  Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| The information collected in this report will be reviewed by staff in Public Health Services (Tasmanian Department of Health). To assist in post-market safety monitoring of vaccines, all reports of AEFI are shared with the Therapeutic Goods Administration (TGA) for assessment. Please notify Public Health Services by email (tas.aefi@health.tas.gov.au) if you do not wish for your report to be shared with the TGA | | | | | | | | | | | | | | | | | | | | | | | | | | | |