

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.	
Parent / Carer Name			Relationship to case				
Address							
Suburb		Postcode		Phone			
Date of Birth or age		Occupation:					
		Workplace / School:					
Aboriginal or Torres Strait Islander		Yes		No		Unknown	
Country Of Birth				Not Australia, specify:			
Language Spoken At Home				Not English (specify)			
HNE Staff Member		Yes		No			
If yes, workplace				Work Ph No.			
<b>Source Of Report</b>							
No.(1,2) who reported:		Hospital		Dr / nurse		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	
Description of event (giving dates and time of events)							

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 & site)	Batch Number	Clinic/GP Postcode
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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
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Was the case unwell at the time of vaccination?  Yes  No  Unknown

<b>Allergies</b>		<input type="checkbox"/>	<b>Yes</b>	<input type="checkbox"/>	<b>No</b>	<input type="checkbox"/>	<b>Unknown</b>		
<b>Congenital anomalies</b>		<input type="checkbox"/>	<b>Yes</b>	<input type="checkbox"/>	<b>No</b>	<input type="checkbox"/>	<b>Unknown</b>		
<b>Convulsions</b>		<input type="checkbox"/>	<b>Yes</b>	<input type="checkbox"/>	<b>No</b>	<input type="checkbox"/>	<b>Unknown</b>		
<b>Epilepsy</b>		<input type="checkbox"/>	<b>Yes</b>	<input type="checkbox"/>	<b>No</b>	<input type="checkbox"/>	<b>Unknown</b>		
<b>Other neurological disorders</b>		<input type="checkbox"/>	<b>Yes</b>	<input type="checkbox"/>	<b>No</b>	<input type="checkbox"/>	<b>Unknown</b>		
<b>Other conditions</b>									
<b>Gestational age</b> (children only)		<input type="checkbox"/>	<b>Birth weight</b>		<input type="checkbox"/>	<b>grams</b>			
If yes to any of above, please describe									
<b>Was medical advice sought?</b>		<input type="checkbox"/>	<b>Yes</b>		<input type="checkbox"/>	<b>No</b>			
<b>Doctor's name</b>					<b>Phone</b>				
<b>Was the case taken to hospital?</b>		<input type="checkbox"/>	<b>Yes</b>	<input type="checkbox"/>	<b>Hospital:</b>				
<b>Was the case hospitalized?</b>		<input type="checkbox"/>	<b>Yes</b>	<input type="checkbox"/>	<b>MRN</b>				
<b>If yes, Admission Date</b>		<input type="checkbox"/>	<b>Discharge Date</b>		<b>Hospital</b>				
<b>VMO</b>	<input type="checkbox"/>	<b>Registrar</b>				<b>Pager</b>	<input type="checkbox"/>		
<b>Has the case recovered?</b>		<input type="checkbox"/>	<b>Yes</b>	<input type="checkbox"/>	<b>No</b>		<b>If yes, date:</b> / /		
<b>How long after the onset did the case recover?</b>				<b>Hours / days / weeks</b>					
<b>If, no, describe condition now:</b>									
<b>If died, Date:</b>		<b>Cause of death</b>							
<b>Type of Adverse Event eg. anaphylaxis, flat/floppy, severe local reaction (Public Health Unit to complete):</b>									
<b>Category (Public Health Unit to complete):</b>		<input type="checkbox"/>	<b>unclear</b>	<input type="checkbox"/>	<b>possible</b>	<input type="checkbox"/>	<b>probable</b>	<input type="checkbox"/>	<b>certain</b>

<b>Follow-Up Management</b> (Public Health Unit to complete):							
<b>Public Health advice offered?</b>							
<b>Was the recommended vaccination schedule altered?</b>		<input type="checkbox"/>	<b>Yes</b>	<input type="checkbox"/>	<b>No</b>	<input type="checkbox"/>	<b>Unknown</b>

<b>Administration of initial report:</b>		<b>Date:</b>
<b>Completed by:</b>		<b>Date:</b>

Please complete all details and fax to: (02) 4924 6490