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| Department of Health  Immunisation section | Tasmanian Government logo |

Adverse Event Following Immunisation (AEFI)

**Reporting Form**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **\*Once completed please email this form to:** [**mailto:tas.aefi@health.tas.gov.au**](mailto:tas.aefi@health.tas.gov.au) | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| The information collected in this report will be reviewed by staff in Public Health Services (Tasmanian Department of Health) to provide advice for immunisation providers and consumers reporting AEFI. 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. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMUNISATION SECTION OFFICE USE ONLY | | | | | | | | | | | | | Initial report  Amendment  Nullification | | | | | | | | | | | | | | |
| Date 1st Received:  ……/……. /…… | | | | Event ID: | | | Date Update Received:  ……./……/…… | | | | | | | | Sender Case Reference: | | | | | | | | | | | | |