

ADVERSE EVENT FOLLOWING IMMUNISATION

Case Details

Surname ----- Given Name ----- Sex M F

DOB --/--/---- or Age ----ys/mths

Address -----

Suburb ----- Postcode -----

Telephone -----

Indigenous Aboriginal y n

Torres St Islander y n

COB Australia y n Other (specify) -----

Language spoken at home English y n Other (specify) -----

AEFI details

Onset date --/--/---

Onset time ----- am/pm

Abscess y n

Osteomyelitis y n

AF Paralysis y n

Parotitis y n

Allergy y n

Rash y n

Anaphylactoid y n

Persist screaming y n

Anaphylaxis y n

Seizure y n

Arthralgia y n

Sepsis y n

Arthritis y n

SSPE y n

Brachial neuritis y n

Thrombocytopenia y n

Death y n

Toxic shock synd. y n

Dissem BCG y n

Paralytic polio y n

Encephalopathy y n

Other severe or unusual event -----

Encephalitis y n

Fever > 40.5 c y n

GBS y n

HH episode y n

Local reaction y n

Lymphadenitis y n

Meningitis y n

Orchitis y n

Osteitis y n

Time between vaccine and AEFI -----days ----- hours

Recovered y n u Recovery date --/--/----

Time ill ----- days ----- hours

Description of event -----

Notification details

Name of Notifier ----- Telephone number -----

Treating Doctor ----- Telephone Number -----
Address -----

Notified date ---/---/----

Outcome

Hospitalised y n Date admitted ---/---/---- Discharge date --/--/----

Name of hospital -----

Deceased y n death date --/--/---- AEFI cause of death y n

Risk Factors

Vaccines in 30 days before AEFI onset:

Vaccine	Dose no	Date Given	Time given	Brand	Batch no
-----	-----	--/--/----	----am/pm	-----	-----
-----	-----	--/--/----	----am/pm	-----	-----
-----	-----	--/--/----	----am/pm	-----	-----
-----	-----	--/--/----	----am/pm	-----	-----
-----	-----	--/--/----	----am/pm	-----	-----
-----	-----	--/--/----	----am/pm	-----	-----

Was the person ill at vaccination y n

Paracetamol given prior to vaccination y n

Medical History

Birth gestation (weeks) -----

Birth weight -----

Allergies y n Specify -----

Congenital abnormalities y n Specify -----

Convulsions y n Specify -----

Epilepsy y n Specify -----

Other Neurological y n Specify -----

Other medical problems y n Specify -----

Please fax completed form to the Public Health Unit on 66 202552.