Dec 2020

Mapped AEFI reporting form

AEFI reporting id number:

STANDARD REPORTING FORM FOR ADVERSE EVENTS FOLLOWING IMMUNIZATION

Patient name or initials:

Patient's full Address:

Telephone:

Sex: ☐ M ☐ F (Trimester I ☐ II ☐ III ☐ /Lactating ☐)

Date of birth (DD/MM/YYYY): _ _/_ _/_ _ _ _

OR Age at onset : ☐☐ *Years* ☐☐ *Months* ☐☐☐ *Days*

OR Age Group: ☐ 0 < 1 year ☐ 1- 5 years ☐ > 5 years - 18 years ☐ > 18 years – 60 years ☐ > 60 years

Reporter's Name:

Institution:

Designation &Department:

Address:

Telephone & e-mail:

Date patient notified event to health system (DD/M

_ _/_ _/_ _ _ _

Today's date (DD/MM/YYYY): _ _/_ _/_ _ _ _

Health facility (or vaccination centre) name:

		Vaccine					*Diluent*		
Name of vaccine (Generic)	***Brand Name incl. Name of Manufacturer***	***Date of vaccination***	***Time of vaccination***	Dose (1st, 2nd, etc.)	***Batch/ Lot number***	Expiry date	***Batch/ Lot number***	Expiry date	Time of reconstitution

Adverse event (s):

☐ Severe local reaction ☐ *>3 days* ☐ *beyond nearest joint*
☐ Seizures ☐ *febrile* ☐ *afebrile*
☐ Abscess
☐ Sepsis
☐ Encephalopathy
☐ Toxic shock syndrome
☐ Thrombocytopenia
☐ Anaphylaxis
☐ Fever≥38°C
☐ Other (spec.....

Date & Time A (DD/MM/YYYY):
__ __ / __ __ / __ __ __ __ ☐☐ Hr ☐☐ Min

Describe AEFI (Signs and symptoms):

Serious: Yes / No ; ➔ If Yes ☐ Death ☐ Life threatening ☐ Disability ☐ Hospitalization ☐ Congenital anomaly ☐ Other important medical event (Specify_____)

Outcom ☐ Recovering ☐ Recovered ☐ Recovered with sequelae ☐ Not Recovered ☐ Unknown

☐ Died of death (DD/MM/YYYY): __ __ / __ __ / __ __ __ __ Autopsy done: ☐ Yes ☐ No ☐ Unknown

Past medical history (including history of similar reaction or other allergies), concomitant medication and dates of administration (exclude those used to treat reaction) other relevant information (e.g. other cases). *Use additional sheet if needed :*

First Decision making level to complete:

Investigation needed: ☐ Yes ☐ No

If yes, date investigation planned (DD/MM/YYYY):
__ __ / __ __ / __ __ __ __

National level to complete:

Date report received at national level (DD/MM/YYYY):
__ __ / __ __ / __ __ __ __

AEFI worldwide unique ID :

Comments:

**Compulsory field*

Description	# Core variable	Suggested Heading	Terminology used in the WHO standard AEFI reporting form	Description
Record Identifier	1	Date AEFI report first received at national centre	**Date report received at national level**	Date this report was received at the National level
	2	Place of vaccination	**Health facility (or vaccination centre) name**	Geographic location of the place where recipient got vaccinated
	3	Country where this AEFI reported	**Reporter address**	The name of the country where the data is first entered
	4	Location (address)	**Patient's full Address**	Geographic location of the case (province)
	5	Worldwide unique number	**AEFI worldwide unique ID**	Unique number used for communicating the details of the case at the international level
Patient	6	Patient identifier	**Patient name or initials**	The name of the patient or initials as decided by the country
	7	Date of birth (or)	**Date of birth**	Date patient was born
	7	Age at time of onset (or)	**Age at onset**	If date of birth is not known, this may be considered as first alternative
	7	Age group at onset	**Age Group**	If date of birth and age at onset is not known, this may be considered as second alternative
	8	Sex	**Sex**	Male or Female
	9	History of Event	**Describe AEFI (Signs and symptoms):**	Free text
Vaccine	10	Primary suspect vaccine name (generic)	**Name of vaccine (Generic)**	The vaccine that is suspected to have caused the AEFI (Generic)
	10	Primary suspect vaccine name (brand)	**Brand Name incl. Name of Manufacturer**	The vaccine that is suspected to have caused the AEFI (Brand name)
	11	Other vaccines given just prior to AEFI	**Other vaccines**	Other vaccines given prior to the AEFI
	12	Vaccine Batch number	**Batch/ Lot number**	Batch number/lot number of each of the vaccines mentioned above
	13	Vaccine dose number for this particular vaccinee	**Dose (1st, 2nd, etc.)**	The dose number for the vaccinee
	14	Diluent batch/ lot number	**Diluent Batch/ Lot number**	Batch number/lot number of the diluent that was actually used (if applicable)
Event	15	Date and time of vaccination	**Date & Time of vaccination**	Date and time when the vaccine was administered
	16	Date and time of AEFI onset	**Date & Time AEFI started**	Date and time the event was first identified by/ in the recipient
	17	Adverse event	**Adverse Event(s)**	The case diagnosis + signs and symptoms
	18	Outcome of AEFI	**Outcome**	Indicate status of the patient at the time of reporting: Recovering, Recovered, Recovered with sequelae, Not Recovered, Unknown or Died
	19	Serious	**Serious**	If the event resulted in death, threatened the patient's life, caused disability, hospitalization or congenital anomaly
Reporter	20	Name of first reporter of AEFI	**Reporter's Name**	Name of person who has reported this AEFI to the healthcare system and also completed this form
	21	Institution/location	**Institution**	The place where the reporter is working or is affiliated to
	22	Position/department	**Designation & Department**	Reporter's designation
	23	e-mail Id & Telephone number	**Telephone & e-mail**	email id of the reporter
	24	Date of report	**Today's date**	Date when the report was compiled by the reporter
Other	25	Comments (if any)	**Comments**	Free text