AEFI reporting id number:

STANDARD REPORTING FORM FOR ADVERSE EVENTS FOLLOWING IMMUNIZATION (AEFI)

***Patient name or initials*:** ***Patient's full Address*:** Telephone: Sex: ☐ M ☐ F (Pregnant - 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/MM/YYYY): _ _/_ _/_ _ _ _ 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 (specify)…….. Date & Time AEFI started (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_____)

Outcome: ☐ Recovering ☐ Recovered ☐ Recovered with sequelae ☐ Not Recovered ☐ Unknown

☐ Died If died, date 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*