AEFI CASE REPORTING FORM

AEFI REPORTING ID : _____ (TO BE ALOTTED BY BIOMED)

(To be submitted within 24 hours of case notification)

State	**District**
Block/ Ward	**Village/ Urban Area**
Address of the Site:	
Notified by (Name):	Designation (please circle): health worker/ government doctor/ private practitioner/ community/ media/ others (specify)
Date: __ __/ __ __/ __ __ __ __	_____ _____
Contact phone number (with STD code):	

Patient Name:																		

Age/ Date of Birth:	Sex	Male	Female

Father's Name/ Husband Name																		

Complete Residential Address of the case with landmarks (Street name, house number, village, block, tehsil, Pin No. etc.)

P	**I**	**N**	**-**							**P**	**H**	**O**	**N**	**E**	**-**			

Date of vaccination	D	D	M	M	Y	Y	Y	Y	Time of vaccination	H	H	M	M	(AM	PM)

Address of session site:

Place of vaccination :Govt Health Facility/Outreach/Private Health facility/others

Date of First Symptom	D	D	M	M	Y	Y	Y	Y	Time of First Symptom	H	H	M	M	(AM	PM)

Details of vaccine, diluents & Vitamin A given to the patient on day of event

Name of vaccines received (write vaccine & diluent details in separate rows)	Dose no. (zero/ first/ second etc. as applicable)	Name of manufacturer	Batch/ lot no.	Mfg. date	Expiry date	Date of opening of vial	Time of opening the vial (for reconstituted vaccine)	No. of OTHER beneficiaries who received vaccine from the SAME vial in this session

Details of hospitalization:

Hospitalization: No/Yes (date)	D	D	M	M	Y	Y	Y	Y	Time of Hospitalization	H	H	M	M	a. m.	p. m.

Name and address of hospital (if hospitalized): _____

_____

_____

Current Status (encircle)	**Death/ Still Hospitalized/ Recovered & Discharged/ Left Against Medical Advice (LAMA)/Recovered completely and discharged/Not Hospitalized.**														
If Died, Date of Death	D	D	M	M	Y	Y	Y	Y	Time of Death	H	H	M	M	(AM	PM)

Post mortem done? (*encircle*)	Yes**/ No/ Planned on (Date) _____	If Yes, Date _____ Time _____

Describe AEFI (signs and symptoms):

_____

_____

_____

_____

Suspected adverse event(s) (tick at least one):

☐ Severe local reaction ☐ Seizures

○ *>3 days* ○ *febrile*

○ *Beyond nearest joint* ○ *afebrile*

☐ Abscess ☐ Sepsis ☐ Encephalopathy ☐ Toxic Shock Syndrome

☐ Thrombocytopenia ☐ Anaphylaxis ☐ Intussusception

☐ Fever ≥ 39 °C (102 °F) ☐ Hypotonic hypo-responsive episode (HHE)

☐ Acute flaccid paralysis ☐ Sudden Unexplained death syndrome.

☐ Death due to any reason other than above – specify _____

_____

☐ Hospitalization due to any reason other than above – specify _____

_____

☐ Disability ☐ Cluster – is this case part of a cluster? Yes/ no/ unknown

If yes, no of other cases in the cluster_____ (use separate form for each case in a cluster)

Signature and Date of reporting/ verifying person: - _____ **Email Id:** _____

Proposed date of investigation: - ____/____/_____

Review By :
(Sign/Date)
Notes/ Comments: _____