

BIO-MED
PRIVATE LIMITED

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 Format No. : BM/PV/ANX/001B
 SOP Ref. : BM/PV/001
 Revision No. : 07
 Effective Date : 01/02/2022
 To be reviewed : 31/01/2024
 Replaces Revision : 06

AEFI CASE REPORTING FORM
AEFI REPORTING ID : _____ (TO BE ALOTTED BY BIOMED)
 (To be submitted within 24 hours of case notification)

REPORTER DETAILS :

Notified by (Name):	Designation (please circle): health worker/ government doctor/ private practitioner/ community/ media/ others (specify)
Date: ___/___/_____	_____
Contact phone number (with STD code):	Email ID : _____
ADDRESS AT THE SITE OF EVENT:	
State	District
Complete Address:	

PATIENT INITIAL:-

Patient Name:															
Age/ Date of Birth:							Sex	Male	Female						
Weight (in Kg)	_____														

EVENT DETAILS :-

Date of reaction started : _____	Date of reaction stopped : _____		
Suspected adverse event(s) (tick at least one):			
<input type="checkbox"/> Severe local reaction	<input type="checkbox"/> Seizures		
<input type="radio"/> >3 days	<input type="radio"/> febrile		
<input type="radio"/> Beyond nearest joint	<input type="radio"/> afebrile		
<input type="checkbox"/> Abscess	<input type="checkbox"/> Sepsis	<input type="checkbox"/> Encephalopathy	<input type="checkbox"/> Toxic Shock Syndrome
<input type="checkbox"/> Thrombocytopenia	<input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> Intussusceptions	
<input type="checkbox"/> Fever ≥ 39 °C (102 °F)	<input type="checkbox"/> Hypotonic hypo-responsive episode (HHE)		
Acute flaccid paralysis	<input type="checkbox"/> Sudden Unexplained death syndrome	<input type="checkbox"/>	
Other	<input type="checkbox"/> (Specify below)		

Describe AEFI (signs and symptoms):

VACCINATION DETAILS :-

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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

Date & time of Start of vaccination:-

Date & time of Stop of vaccination:-

Seriousness (Yes/NO):-If Yes then proceed further & If No then write the outcome of Event.

Death

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? (<i>encircle</i>)					Yes/ No/ Planned on (Date) _____					If Yes, Date _____ Time _____					

Hospitalization

Hospitalization: No/Yes (date)	D	D	M	M	Y	Y	Y	Y	Time of Hospitalization	H	H	M	M	a. m.	p. m.
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Name and address of hospital (if hospitalized): _____

Congenital Anomaly Required intervention to prolonged hospitalization

Life threatening Disability

Other (specify) _____
