CASE REPORTING FORM FOR ADVERSE EVENT FOLLOWING IMMUNIZATION (AEFI)

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 Medical Practitioner/ Community/ Media/ Others (Specify) _____

Date: __ __/ __ __/ __ __ __ __

Contact phone number (with STD code): _____

Email ID :_____

ADDRESS AT THE SITE OF EVENT:		
State	**District**	
Complete Address:		
Health Facility (or vaccination centre) name:		

- **PATIENT INITIALS:-**

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

- **EVENT DETAILS :-**

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

☐ Severe local reaction ☐ Seizures ☐ Transient hyperthermia

○ *>3 days* ○ *febrile*

○ *Beyond nearest joint* ○ *afebrile*

☐ Abscess ☐ Sepsis ☐ Encephalopathy ☐ Toxic Shock Syndrome ☐ Thrombocytopenia

☐ Anaphylaxis ☐ Intussusceptions ☐ Redness, Pain at the site of injection ☐ Fever ≥ 39 ºC (102 ºF)

☐ Hypotonic hypo-responsive episode (HHE) ☐ Induration ☐ Headache ☐ Vomiting

☐ Sudden Unexplained death syndrome ☐ Pruritus ☐ Erythema at the site of injection ☐ Skin rashes

☐ Other (Specify)…….

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

Describe AEFI (signs and symptoms):

_____

_____

_____

_____

_____

- **VACCINATION DETAILS :-**

Vaccine					**Diluent**		
Name of vaccine (Generic)	Brand Name incl. name of Manufacturer	Dose (1st / 2nd/ etc. as applicable)	Batch/ Lot no.	Expiry date	Batch/ Lot no.	Expiry date	Time of reconstitution

Date of vaccination: __ __/ __ __/ __ __ __ __ **Time of vaccination:** ☐☐ Hr ☐☐ Min

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? (*encircle*)	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.

Name and address of hospital (if hospitalized):_____

_____

_____

Congenital Anomaly ☐ **Required intervention to prolonged hospitalization** ☐

Life threatening ☐ **Disability** ☐

Other (specify)_____

_____

- **Outcome :-**

Fatal ☐ **Unknown** ☐ **Recovered** ☐

Recovering ☐ **Not Recovered** ☐

FOR OFFICE USE ONLY:-

- **Causality Assessment :-**
  - Consistent with causal association to immunization ☐
  - Indeterminate ☐
  - Inconsistent with causal association to immunization ☐
  - Unclassifiable ☐

Reviewed By :
(Sign/Date)

Proposed date of investigation (If required): - _____/_____/_____

Comments:

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