Department of Health
COMMUNICABLE DISEASES PREVENTION UNIT
IMMUNISATION SECTION

Tasmanian Government

Adverse Event Following Immunisation (AEFI)
Reporting Form

Vaccinated Person Details

First Name:	Surname:	DOB: / /
Address:	Suburb:	Postcode:
Email:	Mobile:	Gender: ☐ Male ☐ Female ☐ Other

Indigenous status: ☐ Aboriginal ☐ Torres Strait Islander ☐ Both Aboriginal and Torres Strait Islander ☐ Neither

Parent/Guardian Details (if applicable)

First Name:	Surname:
Email:	Mobile:

Person Reporting Details

Report Date: / /

Relationship to Vaccinated Person:	☐ Self (as above)	☐ Parent/Guardian (as above)	☐ Doctor	☐ Nurse/Midwife
	☐ Other (please specify):			

First Name:	Surname:	Email:
Organisation Name:		Phone:

Consent

I give consent for the Communicable Diseases Prevention Unit Immunisation Section to:

- Contact the person reporting the event ☐ Yes ☐ No
- Contact the immunisation provider listed ☐ Yes ☐ No ☐ N/A

Immunisation Provider Details

Who provided the vaccine:	☐ Doctor	☐ Nurse/Midwife	☐ Pharmacist	☐ Unknown
	☐ Other (please specify):			

Location:	☐ GP	☐ Council	☐ Aboriginal Health	☐ Hospital	☐ School	☐ State Run Clinic
	☐ RACF	☐ Unknown	☐ Other (please specify):			

First Name:	Surname:	Phone:
Address:	Suburb:	Postcode:

Medical History

Illness at the time of vaccination?	☐ Yes ☐ No ☐ Unknown
Received any other vaccine in the last 4 weeks?	☐ Yes ☐ No ☐ Unknown
Taken any medicines in the last 3 months?	☐ Yes ☐ No ☐ Unknown
Any <u>important</u> pre-existing medical conditions, including severe allergies?	☐ Yes ☐ No ☐ Unknown

Pregnant at the time of vaccination? ☐ Yes ☐ No ☐ N/A ☐ Unknown **Gestation** (if known): weeks

<u>Only if aged under 2 years:</u> Gestation at birth: weeks Birth weight: grams

Details: *(please complete if 'yes' to any of the above)*

Vaccines Administered

☐ **Tick if you do not know which vaccine was administered, and skip to "Adverse Event Description"**

Date of Vaccination: / /			Time of Vaccination: (24hr clock)	
Vaccine Name	Dose No.	Batch Number	Route of Administration*	Site*
			☐ IM ☐ Oral ☐ SC ☐ ID ☐ Unknown	☐ LA ☐ RA ☐ LL ☐ RL ☐ O ☐ Unknown
			☐ IM ☐ Oral ☐ SC ☐ ID ☐ Unknown	☐ LA ☐ RA ☐ LL ☐ RL ☐ O ☐ Unknown
			☐ IM ☐ Oral ☐ SC ☐ ID ☐ Unknown	☐ LA ☐ RA ☐ LL ☐ RL ☐ O ☐ Unknown
			☐ IM ☐ Oral ☐ SC ☐ ID ☐ Unknown	☐ LA ☐ RA ☐ LL ☐ RL ☐ O ☐ Unknown

**IM = Intramuscular, SC = Subcutaneous, ID = Intradermal, LA = Left Arm, RA = Right Arm, LL = Left Leg, RL = Right Leg, O = Other Site (please specify):*____

If Bexsero vaccine was administered and the child is less than 2 years old, did they receive paracetamol before or at the time of vaccination?	☐ Yes ☐ No ☐ N/A
If Bexsero vaccine was administered, did the child have the two further recommended doses of paracetamol after vaccination?	☐ Yes ☐ No ☐ N/A
Are you completing this form to report a vaccine administration error? *If yes, please provide the specific details in the 'details of event' box below.*	☐ Yes ☐ No

Adverse Event Description

Onset Date: / / Onset Time (if known): (24hr clock)

Time from vaccination to onset of symptoms: days hours minutes

Outcome of event: ☐ Recovered ☐ Ongoing ☐ Recovered with complications ☐ Fatal ☐ Unknown

Recovery Date (if relevant): / /

Details of event: *(be as descriptive as you can)*

Treatment Details

Treatment Type			
☐ Self (did not seek medical assistance)	☐ Helpline	☐ Nurse	☐ GP
☐ Hospital Emergency	☐ Specialist Outpatient Clinic	☐ Unknown	
☐ Hospital Admission: Number of days Admitted:	Date of discharge: / /		

Treatment Received:

Organisation Name:	Phone:

COVID-19 Check

Has the vaccinated person **ever** had a COVID-19 infection? ☐ Yes ☐ No ☐ Unknown

If yes, the last known date of infection is / / **OR** ☐ Unknown

***Once completed please email this form to: tas.aefi@health.tas.gov.au**

The information collected in this report will be reviewed by staff in Public Health Services (Tasmanian Department of Health) to provide advice for immunisation providers and consumers reporting AEFI. To assist in post-market safety monitoring of vaccines, all reports of AEFI are shared with the Therapeutic Goods Administration (TGA) for assessment. Please notify Public Health Services by email (tas.aefi@health.tas.gov.au) if you do not wish for your report to be shared with the TGA.

IMMUNISATION SECTION OFFICE USE ONLY		☐ Initial report ☐ Amendment ☐ Nullification	
Date 1st Received: ……/……./……	Event ID:	Date Update Received: ……./……/……	Sender Case Reference: