

Adverse Event Following Immunisation (AEFI) Reporting Form

Vaccinated Person Details						
First Name:	Surname:	DOB: / /				
Address:	Suburb:	Postcode:				
Email:	Mobile:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other				
Indigenous status: <input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Both Aboriginal and Torres Strait Islander <input type="checkbox"/> Neither						
Parent/Guardian Details (if applicable)						
First Name:		Surname:				
Email:		Mobile:				
Person Reporting Details						
Report Date: / /						
Relationship to Vaccinated Person:	<input type="checkbox"/> Self (as above)		<input type="checkbox"/> Parent/Guardian (as above)		<input type="checkbox"/> Doctor	<input type="checkbox"/> Nurse/Midwife
	<input type="checkbox"/> 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		<input type="checkbox"/> Yes <input type="checkbox"/> No				
• Contact the immunisation provider listed		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> N/A		
Immunisation Provider Details						
Who provided the vaccine:	<input type="checkbox"/> Doctor		<input type="checkbox"/> Nurse/Midwife		<input type="checkbox"/> Pharmacist	<input type="checkbox"/> Unknown
	<input type="checkbox"/> Other (please specify):					
Location:	<input type="checkbox"/> GP	<input type="checkbox"/> Council	<input type="checkbox"/> Aboriginal Health	<input type="checkbox"/> Hospital	<input type="checkbox"/> School	<input type="checkbox"/> State Run Clinic
	<input type="checkbox"/> RACF	<input type="checkbox"/> Unknown	<input type="checkbox"/> Other (please specify):			
First Name:		Surname:			Phone:	
Address:			Suburb:		Postcode:	
Medical History						
Illness at the time of vaccination?				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Received any other vaccine in the last 4 weeks?				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Taken any medicines in the last 3 months?				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Any <u>important</u> pre-existing medical conditions, including severe allergies?				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Pregnant at the time of vaccination? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Unknown				Gestation (if known): weeks		
Only if aged under 2 years:		Gestation at birth: weeks		Birth weight: grams		
Details: (please complete if 'yes' to any of the above)						

Vaccines Administered					
<input type="checkbox"/> Tick if you do <u>not</u> 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*	
			<input type="checkbox"/> IM <input type="checkbox"/> Oral <input type="checkbox"/> SC <input type="checkbox"/> ID <input type="checkbox"/> Unknown	<input type="checkbox"/> LA <input type="checkbox"/> RA <input type="checkbox"/> LL <input type="checkbox"/> RL <input type="checkbox"/> O <input type="checkbox"/> Unknown	
			<input type="checkbox"/> IM <input type="checkbox"/> Oral <input type="checkbox"/> SC <input type="checkbox"/> ID <input type="checkbox"/> Unknown	<input type="checkbox"/> LA <input type="checkbox"/> RA <input type="checkbox"/> LL <input type="checkbox"/> RL <input type="checkbox"/> O <input type="checkbox"/> Unknown	
			<input type="checkbox"/> IM <input type="checkbox"/> Oral <input type="checkbox"/> SC <input type="checkbox"/> ID <input type="checkbox"/> Unknown	<input type="checkbox"/> LA <input type="checkbox"/> RA <input type="checkbox"/> LL <input type="checkbox"/> RL <input type="checkbox"/> O <input type="checkbox"/> Unknown	
			<input type="checkbox"/> IM <input type="checkbox"/> Oral <input type="checkbox"/> SC <input type="checkbox"/> ID <input type="checkbox"/> Unknown	<input type="checkbox"/> LA <input type="checkbox"/> RA <input type="checkbox"/> LL <input type="checkbox"/> RL <input type="checkbox"/> O <input type="checkbox"/> 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?				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
If Bexsero vaccine was administered, did the child have the two further recommended doses of paracetamol after vaccination?				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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.				<input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Recovered <input type="checkbox"/> Ongoing <input type="checkbox"/> Recovered with complications <input type="checkbox"/> Fatal <input type="checkbox"/> Unknown					
Recovery Date (if relevant): / /					
Details of event: (be as descriptive as you can)					
Treatment Details					
Treatment Type	<input type="checkbox"/> Self (did not seek medical assistance)		<input type="checkbox"/> Helpline	<input type="checkbox"/> Nurse	<input type="checkbox"/> GP
	<input type="checkbox"/> Hospital Emergency		<input type="checkbox"/> Specialist Outpatient Clinic		<input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
If yes, the last known date of infection is / / OR <input type="checkbox"/> 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			<input type="checkbox"/> Initial report <input type="checkbox"/> Amendment <input type="checkbox"/> Nullification		
Date 1 st Received:/...../.....	Event ID:	Date Update Received:/...../.....	Sender Case Reference:		