FORM FOR REPORTING AN ADVERSE EVENT FOLLOWING IMMUNISATION

SAEFVIC Office Use Only

EVENT ID ☐☐☐☐☐☐

Date Received ___/___/___

Please forward to **SAEFVIC** (**S**urveillance of **A**dverse **E**vents **F**ollowing **V**accination in the **C**ommunity): 5th floor East Building, Royal Children's Hospital, Flemington Rd, Parkville, VIC 3052 Fax 9345 4163 Phone: 1300 882 924 (Option 1)

Online reporting also available via www.saefvic.org.au

VACCINEE DETAILS (CHILD OR ADULT)

First Name

_____

Surname

_____

Date of birth __/__/__ ❒ **Aboriginal** ❒ **Torres Strait Islander**

Sex ❒ Male ❒ Female ❒ Unknown

Medicare Number

☐☐☐☐☐☐☐☐☐☐ ☐

Address

_____

_____

Suburb **Postcode**

PARENT/GUARDIAN DETAILS (IF APPLICABLE)

Title

❒Dr ❒Mr ❒Ms ❒Mrs ❒Miss ❒Other

Parent/Guardian Name

_____

Phone

_____

Email

_____

REPORTER DETAILS

FORM COMPLETION DATE: ___/___/___

Type of reporter

❒Doctor ❒Nurse ❒Self ❒Parent/Guardian

❒Other (Specify)_____

Title

❒Dr ❒Mr ❒Ms ❒Mrs ❒Miss ❒Other

Name

_____

Organisation

_____

_____

Address

_____

_____

Suburb **Postcode**

Phone

_____

Email

_____

IMMUNISATION PROVIDER DETAILS

Provider details same as reporter details ❒

If vaccine was NOT given with the reporter please include administration location details

Type ❒GP ❒Council ❒ Hospital ❒ Workplace ❒ Interstate/Overseas ❒Other (Specify)_____ ❒Unknown

Title ❒Dr ❒Mr ❒Ms ❒Mrs ❒Miss ❒Other

Name

_____

Organisation

_____

_____

Address

_____

_____

Suburb **Postcode**

Phone _____

Email:_____

Name (Vaccinee):

CONSENT (to be contacted by SAEFVIC)

❒ The vaccinee/parent/guardian **consent** to be contacted

❒They **do not** consent to be contacted ❒ Consent is still being **sought**

Signature _____ **Date** __/__/__

VACCINES ADMINISTERED

Date of Vaccination __/__/__ Unknown ❒ Time ☐☐:☐☐ AM/PM Unknown ❒

Antenatal Vaccination ❒ Weeks of gestation_____

Vaccine	Dose No.	Batch No. (if known)
	☐	☐☐☐☐☐☐☐☐☐☐
	☐	☐☐☐☐☐☐☐☐☐☐
	☐	☐☐☐☐☐☐☐☐☐☐
	☐	☐☐☐☐☐☐☐☐☐☐

REACTION DETAILS (include medical history if relevant)

Time elapsed between the administration of the vaccine and the onset of symptoms

☐ # Minutes ☐ # Hours ☐ # Days ☐ # Weeks ☐ Unknown

Detailed description of reaction including timing of events:

TREATMENT (tick one or more boxes)

❒ Unknown

❒ None or symptomatic (e.g. paracetamol) only

❒ Parent help-line

❒ Nurse assessment

❒ Other (please specify)_____

❒ GP assessment

❒ Hospital emergency at _____

❒ Hospital Admission at _____

Days_____Unknown ❒

Details:

OUTCOME

How long did the symptoms last?

☐ # Minutes ☐ # Hours ☐ # Days ☐ # Weeks ☐ Unknown but resolved ☐ Unknown but ongoing

Description of outcome: ☐ Unknown