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 West, The Royal Children's Hospital, 50 Flemington Rd, Parkville, VIC 3052 Fax 9345 4163 Phone: 1300 882 924 (Option 1) Hours: Mon – Fri, 9am – 4pm

Online reporting is available on www.aefican.org.au

VACCINEE DETAILS (CHILD OR ADULT)

First Name

_____

Surname

_____

Date of Birth __/__/__ **Gender** ❒ M ❒ F ❒ Unknown

Phone

_____

Email

_____

Ethnicity ❒ Aboriginal ❒ Non-Aboriginal ❒ Torres Strait Islander ❒ Unknown

Medicare Number

❒❒❒❒❒❒❒❒❒❒ ❒

Address

_____

_____

Suburb_____ **Postcode**_____

PARENT/GUARDIAN DETAILS (IF APPLICABLE)

❒Dr ❒Mr ❒Ms ❒Mrs ❒Miss ❒Other

Parent/Guardian Name

_____

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 ❒

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

❒Dr ❒Mr ❒Ms ❒Mrs ❒Miss ❒Other

Name

_____

Organisation

_____

_____

Address

_____

_____

Suburb_____ **Postcode**_____

Phone _____

Email _____

Name (Vaccinee):

CONSENT FOR SAEFVIC TO CONTACT VACCINEE/ PARENT/ GUARDIAN

❒ **Full consent** was obtained from the vaccinee/ parent/ guardian

❒ Consent to report, but **do not contact** vaccinee/ parent/ guardian

Signature _____

Date __/__/__

VACCINES ADMINISTERED

Date of Vaccination __/__/__ Unknown ❒

Time ❒❒:❒❒ AM/PM Unknown ❒

Antenatal Vaccination ❒

Weeks of Gestation _____

Vaccine	Dose No.	Batch Number	Injection Site (Please specify)
	❒	❒❒❒❒❒❒❒❒❒❒	
	❒	❒❒❒❒❒❒❒❒❒❒	
	❒	❒❒❒❒❒❒❒❒❒❒	
	❒	❒❒❒❒❒❒❒❒❒❒	

REACTION DETAILS (include medical history if relevant)

Time elapsed between administration of the vaccine and the onset of symptoms (e.g. **3** minutes/ **4** days)

❒Minutes ❒Hours ❒Days ❒Weeks ❒Unknown

Detailed description of reaction including timing of events:

TREATMENT (tick one or more boxes and specify details)

❒ 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
(e.g. **3** minutes/ **4** days)

Detailed description of outcome ❒ Unknown