**FORM FOR REPORTING AN ADVERSE EVENT FOLLOWING IMMUNISATION**

**SAEFVIC**  Office Use Only

**EVENT ID** □□□□□□□□

**Date Received** __/__/__

Please forward to **SAEFVIC** (Surveillance of Adverse Events Following Vaccination In the Community): 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](http://www.aefican.org.au)

### VACCINEE DETAILS (CHILD OR ADULT)

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
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</thead>
<tbody>
<tr>
<td>First Name</td>
<td></td>
</tr>
<tr>
<td>Surname</td>
<td></td>
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<tr>
<td>Date of Birth</td>
<td><strong>/</strong>/__</td>
</tr>
<tr>
<td>Gender</td>
<td>□ M □ F □ Unknown</td>
</tr>
<tr>
<td>Phone</td>
<td></td>
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<tr>
<td>Email</td>
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</tbody>
</table>
| Ethnicity              | □ Aboriginal □ Non-Aboriginal
|                       | □ Torres Strait Islander □ Unknown |
| Medicare Number        |         |
| Address                |         |
| Suburb                 |         |
| Postcode               |         |

### REPORTER DETAILS

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
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<tbody>
<tr>
<td>Form Completion Date</td>
<td><strong>/</strong>/__</td>
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</tbody>
</table>

**Type of Reporter**

- [ ] Doctor
- [ ] Nurse
- [ ] Self
- [ ] Parent/Guardian
- [ ] Other (Specify) __________

**Title**

- [ ] Dr
- [ ] Mr
- [ ] Ms
- [ ] Mrs
- [ ] Miss
- [ ] Other

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<tr>
<td>Name</td>
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<td>Organisation</td>
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<td>Address</td>
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### PARENT/GUARDIAN DETAILS (IF APPLICABLE)

- [ ] Dr
- [ ] Mr
- [ ] Ms
- [ ] Mrs
- [ ] Miss
- [ ] Other

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
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<tr>
<td>Parent/Guardian Name</td>
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### 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

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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 ☐
Antenatal Vaccination ☐
Time ☐:☐ AM/PM Unknown ☐
Weeks of Gestation _____________________

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Dose No.</th>
<th>Batch Number</th>
<th>Injection Site (Please specify)</th>
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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 ☐ GP assessment
☐ None or symptomatic (e.g. paracetamol) only ☐ Hospital emergency at ________________________________
☐ Parent help-line ☐ Hospital Admission at ________________________________
☐ Nurse assessment # Days ___________ Unknown ☐
☐ Other (please specify) ________________________________

Details:

OUTCOME

How long did the symptoms last? ☐ Minutes ☐ Hours ☐ Days ☐ Weeks ☐ Unknown
(e.g. 3 minutes/ 4 days)

Detailed description of outcome ☐ Unknown