

IMMUNISATION ADVERSE EVENT REPORTING FORM

OFFICE USE ONLY

ACT CASE NO: _____

TGA CASE NO: _____

1. DETAILS OF PERSON WHO EXPERIENCED THE ADVERSE EVENT

Name _____ DOB ____/____/____
 Gender M/F/ unknown (circle) Address _____
 State _____ Postcode _____ Home phone _____ Mobile _____
 If a child, Parent/Guardian Name _____
 Aboriginal ☐ Torres Strait Islander ☐ Aboriginal & Torres Strait Islander ☐ Neither ☐ Not stated ☐

2. PAST MEDICAL HISTORY

Any known allergies? _____
 Any medical conditions? _____
 Does the person take any routine medications? _____
 Any prior reactions following immunisation? **Yes/No/Unknown:** If Yes, provide details _____

 General Practitioner _____ Phone _____
 Was the person ill before the vaccine was given? **Yes/No** If Yes, provide details _____

3. VACCINATION DETAILS

School program **Yes/No**
 Vaccine Provider Name _____
 Provider Address _____ Suburb _____ Post code _____
 Phone _____ Fax _____ Email _____

Vaccine Brand/Type	Dose No	Date Administered	Time Administered	Batch No	Route/Site/Side (left or right)

Were any other vaccines given within 4 weeks prior to the adverse event? **NO/YES:** If Yes, specify details: _____

4. ADVERSE EVENT DETAILS

Onset of event

Date and time reaction occurred _____
 If unknown, time elapsed between vaccination and adverse event _____
 Detailed description the adverse event _____

Management of event	
None/Nurse/GP/Hospital ED	Was hospitalization required? yes/no
Date of admission ____ / ____ / ____	Date of discharge ____ / ____ / ____
Detailed description of any treatment including medications _____	

Outcome	
Have the symptoms resolved? yes/no/unknown If yes, time and date _____	
If no, symptoms ongoing as of (time and date): _____	
Please describe ongoing symptoms _____	

5. DETAILS OF PERSON REPORTING THIS ADVERSE EVENT	
Name _____	Phone _____ Date: ____ / ____ / ____
Address _____	Suburb _____ Post code _____
Reporter type GP/ Medical Specialist/Medical Practitioner/Nurse RN/EN/Vaccinated person/parent/guardian/ Other _____	
<p>Consent statement</p> <p>Please advise the parent/patient that they may be contacted if additional information is required. The contact details will be used for this purpose.</p> <p>If the parent/patient does not wish to be contacted, please fill out the following:</p> <p>I, the parent/patient do not agree to be contacted. Parent/patient signature _____</p> <p>The person has advised that they do not wish to be contacted (reporter to sign) _____</p> <p>Date _____</p> <p>For verbal reports, indicate how consent was obtained:</p>	
<p><i>Please circle most relevant answer where appropriate.</i></p> <p><i>On completion, fax this form to 6205 1738, or email to: immunisation@act.gov.au</i></p>	
<p>Office use only</p> <p>Is this considered a serious AEFI? Yes/No</p> <p>If yes, please specify _____</p> <p>_____</p> <p>Is follow up on patient required? Yes/No</p> <p>Immediately/next day/next 30 days/next 60 days</p> <p>Date report received _____ Date scanned to TGA _____</p>	