ACT Government | ACT Health

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/Medial Practitioner/Nurse RN/EN/Vaccinated person/parent/guardian/ Other_____

Consent statement

Please advise the parent/patient that they may be contacted if additional information is required. The contact details will be used for this purpose.

If the parent/patient does not wish to be contacted, please fill out the following:

I, the parent/patient do not agree to be contacted. Parent/patient signature_____
The person has advised that they do not wish to be contacted (reporter to sign)_____
Date_____
For verbal reports, indicate how consent was obtained:

Please circle most relevant answer where appropriate.

On completion, fax this form to 02 5124 9307, or email to: immunisation@act.gov.au

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Is this considered a serious AEFI? Yes/No
If yes, please specify_____
_____

Is follow up on patient required? Yes/No Immediately/next day/next 30 days/ next 60 days

Date report received_____ Date scanned to TGA_____