

**REPORTING FORM FOR ADVERSE EVENTS FOLLOWING IMMUNISATION (AEFI)  
MOH-Ghana Health Service/Food & Drugs Authority**

SMC/SMD/GEN- 10/1.0

Reporting: Sub-District:		District:		Region							
<b>AEFI Reporting ID Number</b>				Vaccination Card/Booklet <input type="checkbox"/> Yes <input type="checkbox"/> No							
Region Code		District Code		Year							
Serial Number		If no, state other source of information:									
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>						
<b>A. PATIENT DETAILS</b>											
*Name :			*Date of birth (DD/MM/YYYY): _/ _/ _								
Sex: <input type="checkbox"/> M <input type="checkbox"/> F			OR Age at onset: <input type="checkbox"/> <input type="checkbox"/> Years <input type="checkbox"/> <input type="checkbox"/> Months <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Days								
Mother's Name (if child):			OR Age Group: <input type="checkbox"/> < 1 Year <input type="checkbox"/> 1 to 5 Years <input type="checkbox"/> > 5 Years								
Contact Phone No:			*Address (landmarks and other contact information):								
Vaccination centre:											
Community:											
<b>*B. DESCRIPTION OF AEFI</b>											
<input type="checkbox"/> Severe local reaction <input type="checkbox"/> >3 days <input type="checkbox"/> beyond nearest joint <input type="checkbox"/> Seizures <input type="checkbox"/> febrile <input type="checkbox"/> afebrile <input type="checkbox"/> Abscess <input type="checkbox"/> Sepsis <input type="checkbox"/> Encephalopathy <input type="checkbox"/> Toxic shock syndrome <input type="checkbox"/> Thrombocytopenia <input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Fever ≥38°C <input type="checkbox"/> Other (specify).....			Date AEFI started (DD/MM/YYYY): _ _ / _ _ / _ _ _ _ _ Time AEFI started <input type="checkbox"/> <input type="checkbox"/> Hr <input type="checkbox"/> <input type="checkbox"/> Min Signs and symptoms- please give a summary of the case, including any prior disease(s)/condition and patient's medicines before vaccination)  Indicate treatment given for the AEFI:								
<b>*C. OUTCOME OF AEFI</b>											
* <b>Serious</b> <sup>¶</sup> : <input type="checkbox"/> Yes <input type="checkbox"/> No; → If Yes <input type="checkbox"/> Death <input type="checkbox"/> Life threatening <input type="checkbox"/> Disability <input type="checkbox"/> Hospitalization <input type="checkbox"/> Congenital anomaly											
<input type="checkbox"/> Other important medical event (Specify _____)											
* <b>Outcome</b> : <input type="checkbox"/> Recovering <input type="checkbox"/> Recovered <input type="checkbox"/> Recovered with sequelae <input type="checkbox"/> Not Recovered <input type="checkbox"/> Unknown											
<input type="checkbox"/> Died If died, date of death (DD/MM/YYYY): _ _ / _ _ / _ _ _ _ _ Autopsy done: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown											
<b>D. DETAILS OF ALL VACCINE (S) ADMINISTERED</b>											
<b>VACCINE(S)</b>											
<b>DILUENT (if applicable)</b>											
*Name	*Date and time of Vaccination		*Route (if injection indicate L/R site)	*Lot / Batch No.	Manufacturer	Expiry Date	Manufacturer	*Lot / Batch No.	Expiry Date	Date and time of reconstitution	
	Date	Time								Date	Time
<b>E. REPORTER DETAILS</b>											
*Name:			Profession/Designation:				Tel No.:				
Name of Institution:			Today's Date: _ / _ / _				Signature:				

**For District Level Office**

Date Report Received: _ _ / _ _ / _ _ _ _ _	Checked by:	Designation:
Investigation needed: <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date started: _ _ / _ _ / _ _ _ _ _	

**For National/Central Level Office**

Date Report Received: _ _ / _ _ / _ _ _ _ _	Checked by:	Designation:
Comments (include results of Causality Assessment):		

<sup>¶</sup>All serious AEFIs & AEFI clusters (two or more cases of the same adverse event related in time, place or vaccine administered) should be investigated.

\*Mandatory fields