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

AEFI Reporting ID Number
Region Code ☐☐☐ District Code ☐☐☐ Year ☐☐ Serial Number ☐☐☐

Vaccination Card/Booklet ☐Yes ☐ No

If no, state other source of information:

A. PATIENT DETAILS

*Name :

Sex: ☐ M ☐ F

Mother's Name (if child):

Contact Phone No:

Vaccination centre:

Community:

*Date of birth (DD/MM/YYYY): _ _/_ _/_ _ _ _

OR Age at onset: ☐☐Years ☐☐ Months ☐☐☐ Days

OR Age Group: ☐< 1 Year ☐ 1 to 5 Years ☐ > 5 Years

*Address (landmarks and other contact information):

***B. DESCRIPTION OF AEFI**

☐ Severe local reaction ☐ >3 days ☐ beyond nearest joint
☐ Seizures ☐ febrile ☐ afebrile
☐ Abscess
☐ Sepsis
☐ Encephalopathy
☐ Toxic shock syndrome
☐ Thrombocytopenia
☐ Anaphylaxis
☐ Fever≥38°C
☐ Other (specify).....

Date AEFI started (DD/MM/YYYY): __ __ / __ __ / __ __ __ __

Time AEFI started ☐☐ Hr ☐☐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:

***C. OUTCOME OF AEFI**

***Serious**[¶]**:** ☐ Yes ☐ No**;** ➔ If Yes ☐ Death ☐ Life threatening ☐ Disability ☐ Hospitalization ☐ Congenital anomaly

☐ Other important medical event (Specify_____)

***Outcome:** ☐ Recovering ☐ Recovered ☐ Recovered with sequelae ☐ Not Recovered ☐ Unknown

☐ Died If died, date of death (DD/MM/YYYY): __ __ / __ __ / __ __ __ __ Autopsy done: ☐Yes ☐No ☐Unknown

D. DETAILS OF ALL VACCINE (S) ADMINISTERED

VACCINE(S)							DILUENT (if applicable)				
*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

E. REPORTER DETAILS

*Name: Profession/Designation: Tel No.:

Name of Institution: Today's Date: _ _ /_ _ /_ _ _ _ Signature:

For District Level Office

Date Report Received: _ _ /_ _ /_ _ _ _	Checked by:	Designation:
Investigation needed: ☐ Yes ☐ No	If yes, date started: _ _ /_ _ /_ _ _ _	

For National/Central Level Office

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

[¶]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