AEFI INVESTIGATION FORM

MINISTRY OF HEALTH-GHANA HEALTH SERVICE/FOOD AND DRUGS AUTHORITY

(Only for Serious Adverse Event Following Immunization – Death / Disability / Hospitalization / Cluster)

Section A Basic details

Region **District** **Case ID**

Place of vaccination *(✓)*: ☐ Govt. health facility ☐ Private health facility ☐Other (specify) _____
Vaccination in *(✓)*: ☐ Campaign ☐ Routine ☐ Other (specify) _____

Address of vaccination site:

Name of Reporting Officer:

Date of investigation: __ __ / __ __ / __ __ __ __
Date of filling this form: __ __ / __ __ / __ __ __ __

Designation / Position:

This report is: ☐ *First* ☐ *Interim* ☐ *Final*

Telephone # landline (with code): Mobile: e-mail:

Patient Name Sex: ☐M ☐ F

(use a separate form for each case in a cluster)

Date of birth (DD/MM/YYYY): __ __ / __ __ / __ __ __ __

OR *Age at onset:* __ __ *years* __ __ *months* __ __ __ *days* ***OR*** *Age group:* ☐ *< 1 year* ☐ *1–5 years* ☐ *> 5 years*

Patient's full address with landmarks *(Street name, house number, locality, phone number etc.)*:

Name of vaccines/diluent received by patient	Date of vaccination	Time of vaccination	Dose (e.g. 1st, 2nd, etc.)	Batch/Lot number	Expiry date
				Vaccine	Vaccine
				Diluent	Diluent
				Vaccine	Vaccine
				Diluent	Diluent
				Vaccine	Vaccine
				Diluent	Diluent
				Vaccine	Vaccine
				Diluent	Diluent
				Vaccine	Vaccine
				Diluent	Diluent

Type of site *(✓)* ☐ Fixed ☐ Mobile ☐ Outreach ☐ Other _____

Date of first/key symptom *(DD/MM/YYYY)*: __ __ / __ __ / __ __ __ __ Time of first symptom *(hh/mm)*: __ __ / __ __
Date of hospitalization *(DD/MM/YYYY)*: __ __ / __ __ / __ __ __ __
Date first reported to the health authority *(DD/MM/YYYY)*: __ __ / __ __ / __ __ __ __

Status on the date of investigation (✓): ☐ Died ☐ Disabled ☐ Recovering ☐ Recovered completely ☐Unknown

If died, date and time of death *(DD/MM/YYYY)*: __ __ / __ __ / __ __ __ __ *(hh/mm)*: __ __ / __ __
Autopsy done? (✓) ☐ Yes (date)_____ ☐ No ☐ Planned on (date)_____ Time_____
Attach report (if available)

Section B Relevant patient information prior to immunization

Criteria	Finding	Remarks (If yes provide details)
Past history of similar event	Yes / No / Unkn	
Adverse event after previous vaccination(s)	Yes / No / Unkn	
History of allergy to vaccine, drug or food	Yes / No / Unkn	
Pre-existing illness (30 days) / congenital disorder	Yes / No / Unkn	
History of hospitalization in last 30 days, with cause	Yes / No / Unkn	
Patient currently on concomitant medication? (If yes, name the drug, indication, doses & treatment dates)	Yes / No / Unkn	
Family history of any disease (relevant to AEFI) or allergy	Yes / No / Unkn	

For adult women

- Currently pregnant? Yes (weeks) _____ / No / Unknown
- Currently breastfeeding? Yes / No

For infants

The birth was ☐ full-term ☐ pre-term ☐ post-term. Birth weight:

Delivery procedure was ☐ Normal ☐ Caesarean ☐ Assisted (forceps, vacuum etc.) ☐ with complication (specify)

Section C Details of first examination** of serious AEFI case

Source of information (✓ *all that apply*): ☐ **Examination by the investigator** ☐ **Documents** ☐ **Verbal autopsy** ☐ **Other**_____ *If from verbal autopsy, please mention source* _____

Name of the person who first examined/treated the patient:_____
Name of other persons treating the patient: _____
Other sources who provided information (specify): _____

Signs and symptoms in chronological order from the time of vaccination:

Name and contact information of person completing these clinical details:	Designation:	Date/time

****Instructions – Attach copies of ALL available documents (including case sheet, discharge summary, case notes, laboratory reports and autopsy reports) and then complete additional information NOT AVAILABLE in existing documents, i.e.**

- ***If patient has received medical care*** – attach copies of all available documents (including case sheet, discharge summary, laboratory reports and autopsy reports, if available) and write only the information that is not available in the attached documents below
- ***If patient has not received medical care*** – obtain history, examine the patient and write down your findings below (add additional sheets if necessary)

Provisional / Final diagnosis:

Section D Details of vaccines provided at the site linked to AEFI on the corresponding day

Number immunized for each antigen at session site. Attach record if available.										
	Vaccine name									
	Number of doses									

a)	When was the patient immunized? (✓ the ☐ below and respond to ALL questions)	
	☐ Within the first vaccinations of the session ☐ Within the last vaccinations of the session ☐ Unknown	
	In case of multidose vials, was the vaccine given ☐ within the first few doses of the vial administered? ☐ within the last doses of the vial administered? ☐ unknown?	
b)	Was there an error in prescribing or non-adherence to recommendations for use of this vaccine?	Yes* / No
c)	Based on your investigation, do you feel that the vaccine (ingredients) administered could have been unsterile?	Yes* / No / Unable to assess
d)	Based on your investigation, do you feel that the vaccine's physical condition (e.g. colour, turbidity, foreign substances etc.) was abnormal at the time of administration?	Yes* / No / Unable to assess
e)	Based on your investigation, do you feel that there was an error in vaccine reconstitution/preparation by the vaccinator (e.g. wrong product, wrong diluent, improper mixing, improper syringe filling etc.)?	Yes* / No / Unable to assess
f)	Based on your investigation, do you feel that there was an error in vaccine handling (e.g. break in cold chain during transport, storage and/or immunization session etc.)?	Yes* / No / Unable to assess
g)	Based on your investigation, do you feel that the vaccine was administered incorrectly (e.g. wrong dose, site or route of administration, wrong needle size, not following good injection practice etc.)?	Yes* / No / Unable to assess
h)	Number immunized from the concerned vaccine vial/ampoule	
i)	Number immunized with the concerned vaccine in the same session	
j)	Number immunized with the concerned vaccine having the same batch number in other locations. Specify locations: _____	
k)	Is this case a part of a cluster?	Yes* / No / Unkn
	i. If yes, how many other cases have been detected in the cluster?	
	a. Did all the cases in the cluster receive vaccine from the same vial?	Yes* / No / Unkn
	b. If no, number of vials used in the cluster (enter details separately)	

****It is compulsory for you to provide explanations for these answers separately***

Section E Immunization practices <u>at the place(s) where concerned vaccine was used</u>

(Complete this section by asking and/or observing practice)

Syringes and needles used:

• Are AD syringes used for immunization?	Yes / No / Unkn

If no, specify the type of syringes used: ☐ Glass ☐ Disposable ☐ Recycled disposable ☐ Other _____

Specific key findings/additional observations and comments:

Reconstitution: (complete only if applicable, ✓ NA if not applicable)

	Status		
• Reconstitution procedure (✓)			
Same reconstitution syringe used for multiple vials of same vaccine?	Yes	No	NA
Same reconstitution syringe used for reconstituting different vaccines?	Yes	No	NA
Separate reconstitution syringe for each vaccine vial?	Yes	No	NA
Separate reconstitution syringe for each vaccination?	Yes	No	NA
• Are the vaccines and diluents used the same as those recommended by the manufacturer?	Yes	No	NA

Specific key findings/additional observations and comments:

Section F	**Cold chain and transport** *(Complete this section by asking and/or observing practice)*	
Last vaccine storage point:		
• Is the temperature of the vaccine storage refrigerator monitored?		Yes / No
○ If "yes", was there any deviation outside of 2–8° C after the vaccine was placed inside?		Yes / No
○ If "yes", provide details of monitoring separately.		
• Was the correct procedure for storing vaccines, diluents and syringes followed?		Yes / No / Unkn
• Was any other item (other than EPI vaccines and diluents) in the refrigerator or freezer?		Yes / No / Unkn
• Were any partially used reconstituted vaccines in the refrigerator?		Yes / No / Unkn
• Were any unusable vaccines (expired, no label, VVM at stages 3 or 4, frozen) in the refrigerator?		Yes / No / Unkn
• Were any unusable diluents (expired, manufacturer not matched, cracked, dirty ampoule) in the store?		Yes / No / Unkn
Specific key findings/additional observations and comments:		
Vaccine transportation:		
• Type of vaccine carrier used		
• Was the vaccine carrier sent to the site on the same day as vaccination?		Yes / No / Unkn
• Was the vaccine carrier returned from the site on the same day as vaccination?		Yes / No / Unkn
• Was a conditioned ice-pack used?		Yes / No / Unkn
Specific key findings/additional observations and comments:		

Section G Community investigation (Please visit locality and interview parents/others)

Were any similar events reported within a time period similar to when the adverse event occurred and in the same locality? Yes / No / Unknown If yes, describe:

If yes, how many events/episodes?

Of those effected, how many are
- Vaccinated:_____
- Not vaccinated:_____
- Unknown:_____

Other comments:

Section H Other findings/observations/comments