REPORTING FORM FOR ADVERSE EVENTS FOLLOWING IMMUNISATION (AEFI)-GHANA

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

If Female: Pregnant: ☐ Lactating: ☐

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 ☐ > 5-18 Years ☐ >18-60 Years ☐ > 60 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

AEFI (Signs and symptoms- please give a summary of the case):

Indicate treatment given for the AEFI:

Past medical history (including history of similar reaction or other allergies), concomitant medication and dates of administration (exclude those used to treat reaction) other relevant information (e. g. other cases). Use additional sheet if needed: …….
……..

*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 of Vaccine (Generic/Brand)	*Date and time of Vaccination		*Route (if injection indicate L/R site)	*Lot / Batch No.	Dose (e.g. 1st, 2nd, etc.)	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 ☐ Y ☐ F	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