

## PRE-INVESTIGATION SHEET FOR ADVERSE EVENT(S)

**COUNTRY: REGANDA**

**IMPORTANT NOTE:** This form is part of the Case study A of WHO's E-learning course on Vaccine Safety.  
 It is a simplified draft that should be used for the training purpose of the case study only.  
 It does not represent an official form recommended by WHO!

To: Regional Health Officer

From: Immunization Programme Manager

<p><b>Patient name:</b> <span style="border: 1px solid black; padding: 2px 20px; display: inline-block; margin-left: 100px;">Immunization ID number:</span></p> <p><b>Patient's full Address:</b></p> <p><b>Telephone:</b></p> <p><b>Sex:</b> <input type="checkbox"/> M <input type="checkbox"/> F</p> <p><b>Date of birth (DD/MM/YYYY):</b> ___ / ___ / _____</p>	<p><b>Reporter's Name:</b></p> <p><b>Institution / Designation, Department &amp; address:</b></p> <p><b>Telephone:</b></p>
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<b>Health facility (or vaccination centre) name:</b> Chandra Medical Centre					
Name of vaccines or diluent received	Date of vaccination	Time of vaccination	Dose (e. g. 1 <sup>st</sup> , 2 <sup>nd</sup> , etc.)	Batch/ Lot number	Expiry date

<p><b>Adverse event(s):</b></p> <p><b>Date &amp; Time AEFI started (DD/MM/YYYY):</b>          ___ / ___ / _____    ___ Hr    ___ Min</p> <p><b>Was the patient hospitalized?</b>    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p><b>Date patient notified event to health system (DD/MM/YYYY):</b>          ___ / ___ / _____</p>	<p><b>Describe AEFI (Signs and symptoms):</b>          Drowsiness, Fever, Convulsions/seizures</p>
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<p><b>Outcome:</b></p> <p> <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         </p>
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Past medical history (including history of similar reaction or other allergies), concomitant medication and other relevant information (e.g. other cases). Use additional sheet if needed: No previous problems following immunization.