

REPORTING FORM FOR ADVERSE EVENTS FOLLOWING IMMUNIZATION (AEFI)

<p>*Patient name: Crystal Infendi</p> <p>*Patient's full Address: 17 Owungono Street, Weston region, Omara district Chirunan</p> <p>Telephone: +049346 66 83347</p> <p>Sex: <input type="checkbox"/> M <input checked="" type="checkbox"/> F</p> <p>*Date of birth (DD/MM/YYYY): 03 / 06 / 2009</p> <p>OR Age Group: <input type="checkbox"/> < 1 Year <input type="checkbox"/> 1 to 5 Years <input type="checkbox"/> > 5 Years</p>	<p>*Reporter's Name: Mary Saryna</p> <p>Institution / Designation, Department & address: Chirunan Immunisation Centre 4</p> <p>Telephone & e-mail: +049346 66 78987</p> <p>Date: 05/04/2012 Signature: M. Saryna</p>
---	---

Name of health facility (or vaccination centre):					
*Name of Vaccines Received	*Date of vaccination	*Time of vaccination	Dose (e. g. 1st, 2nd, etc.)	*Batch/ Lot number	Expiry date
MMR Klinigen	04/04/2012	12:30		U-5773	Oct 2012
Easydil	04/04/2012	12:30		SR-2781	April 2013

<p>*Adverse event (s):</p> <p><input type="checkbox"/> Local reaction <input type="checkbox"/> >3 days <input type="checkbox"/> beyond nearest joint</p> <p><input type="checkbox"/> Fever ≥ 38° C</p> <p><input checked="" type="checkbox"/> Seizures <input checked="" type="checkbox"/> febrile <input type="checkbox"/> afebrile</p> <p><input type="checkbox"/> Abscess</p> <p><input type="checkbox"/> Sepsis</p> <p><input type="checkbox"/> Toxic shock syndrome</p> <p><input type="checkbox"/> Thrombocytopenia</p> <p><input type="checkbox"/> Anaphylaxis</p> <p><input type="checkbox"/> Other (specify).....</p> <p>Date & Time AEFI started (DD/MM/YYYY): 05 / 04 / 2012 . 00 Hr 30 Min</p> <p>Was the patient hospitalized? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Date event was notified to health system (DD/MM/YYYY): 05 / 04 / 2012</p>	<p>Describe AEFI (Signs and symptoms):</p>
--	---

***Outcome:**

Recovering Recovered Recovered with sequelae Not Recovered Unknown

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

Past medical history (including history of similar reaction or other allergies), concomitant medication and other relevant information (e.g. other cases). *Healthy – blood counts normal, no evidence for infection (mother has HIV, child is not infected)*

First Decision making level to complete:

Investigation needed: Yes No

If yes, date investigation planned (DD/MM/YYYY):
14 / 04 / 2012

National level to complete:

Date report received at national level (DD/MM/YYYY):
 / /

AEFI worldwide unique ID :

Comments:

**Compulsory field*