# FORM FOR REPORTING AN ADVERSE EVENT FOLLOWING IMMUNISATION

*SAEFVIC Office Use Only*

EVENT ID ❒❒❒❒❒❒

Date Received ___/___/___

Please forward to **SAEFVIC** (**S**urveillance of **A**dverse **E**vents **F**ollowing **V**accination in the **C**ommunity): Fax 9345 4163 Phone: 1300 882 924
5th floor AP1 building, Royal Children's Hospital, Flemington Rd, Parkville, VIC 3052

## VACCINEE DETAILS (CHILD OR ADULT)

**First Name**

_____

**Surname**

_____

**Date of birth** __/__/__

**Sex** ❒ Male ❒ Female ❒ Unknown

**Address**

_____

_____

_____

**Suburb** **Postcode**

**Medicare Number**

❒❒❒❒❒❒❒❒❒❒❒ ❒

**Parent/Guardian Title**

❒Dr ❒A/Prof ❒Prof ❒Mr ❒Ms ❒Mrs ❒Miss

**Parent/Guardian First Name**

_____

**Parent/Guardian Surname**

_____

**Phone One (including area code – e.g (03)12345678) or MOBILE**

_____

**Phone Two (including area code – e.g (03)12345678) or MOBILE**

_____

## REPORTER DETAILS

**FORM COMPLETION DATE: ___/___/___**

**Type of health professional**

❒General Practitioner ❒Nurse ❒Self ❒Other

**Please specify (if other)** _____

**Title**

❒Dr ❒A/Prof ❒Prof ❒Mr ❒Ms ❒Mrs ❒Miss

**Name**

_____

**Organisation/Clinic/GP Surgery/School**

_____

_____

_____

**Address**

_____

_____

_____

**Suburb** **Postcode**

**Phone One (including area code – e.g(03)12345678) or MOBILE**

_____

**Fax**

_____

**Email**

_____

## IMMUNISATION PROVIDER DETAILS

**Type** ❒GP ❒Council ❒School ❒Hospital ❒MCHN ❒Other (Specify)_____ ❒Unknown

**Please provide information about where the vaccine was administered – if DIFFERENT from reporter details**

**Title** ❒Dr ❒A/Prof ❒Prof ❒Mr ❒Ms ❒Mrs ❒Miss

**Name**

_____

**Organisation/Clinic/GP Surgery/School**

_____

**Address**

_____

_____

_____

**Suburb** **Postcode**

**Phone (including area code – e.g (03)12345678) or MOBILE**_____

**Name (Vaccinee):**

## CONSENT (please notify patient/parent/guardian that they will be contacted by SAEFVIC)

I ,the reporter, have obtained verbal consent from the patient/parent/guardian that they are happy to be contacted about the adverse event reported

**Signature** _____ **Date** __/__/__

## VACCINES ADMINISTERED RELATED TO AEFI

Date of Vaccination __/__/__ Unknown ❒ Time (24hr clock e.g 1:25) ❒❒:❒❒ Unknown ❒

| Vaccine | Dose No. | Batch No. (if known) |
|---|---|---|
| | ❒ | ❒❒❒❒❒❒❒❒❒❒ |
| | ❒ | ❒❒❒❒❒❒❒❒❒❒ |
| | ❒ | ❒❒❒❒❒❒❒❒❒❒ |
| | ❒ | ❒❒❒❒❒❒❒❒❒❒ |
| | ❒ | ❒❒❒❒❒❒❒❒❒❒ |

## REACTION DETAILS (include medical history if relevant)

Time elapsed between the administration of the vaccine and the onset of symptoms:

❒ Minutes ❒ Hours ❒ Days ❒ Weeks ❒ Unknown

**Detailed description of reaction including timing of events:**

## TREATMENT (tick one or more boxes)

❒ Not known
❒ None or symptomatic (e.g. paracetamol) only
❒ Parent help-line
❒ Nurse assessment
❒ GP assessment
❒ Hospital emergency
❒ Hospital Admission (No. days ❒) Unknown (days) ❒
❒ Other Please specify (if other)_____

**Details:**

## OUTCOME

Time post vaccination to resolution of symptoms: ❒ Minutes ❒ Hours ❒ Days ❒ Weeks ❒ Unknown

**Detailed description of Outcome** Not known ❒

## FEEDBACK

Have you provided your contact information under “Reporter Details” above?

How would you like your initial feedback from SAEFVIC sent? ❒ Letter ❒ Telephone ❒ Email