REPORTING FORM FOR ADVERSE EVENTS FOLLOWING IMMUNIZATION (AEFI)

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| ***\*Patient Name or initials*:**  ***\*Patient’s full Address*:**  Telephone:  Sex: M FPregnant Lactating  ***\*Date of birth* :** \_ \_ / \_ \_ / \_ \_  *OR Ageatonset: Years Months Days*  *OR Age Groupatonset: <1 Year 1 to5Years >5Years-15 Years >15 years-60 Years >60 years* | ***\*Reporter’s Name*:**  Institution:  Designation & Department:  Address:  Telephone & E-mail:  Date patient notified event tohealthsystem: \_ \_ / \_ \_ / \_\_  Today’s date : \_ \_ / \_ \_ / \_ \_ |

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| **Health facility (place or vaccination center) name & address:** | | | | | | | | | | |
| ***Vaccine*** | | | | | | | ***Diluent (if applicable)*** | | | |
| ***\*Name of vaccine*** | ***\*Brand Name and,Name of Manufacturer*** | ***\*Date of vaccination*** | ***\*Time of vaccination*** | Dose  (1st, 2nd, etc.) | ***\*Batch /Lot number*** | Expiry date | Name of diluent | ***\*Batch /Lot number*** | Expiry date | Date and time of reconstitution |
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| ***\*Adverse event(s):***  Severelocalreaction *>3days beyond nearestjoint*  Seizures *febrile afebrile*  Abscess Sepsis  Encephalopathy  Toxic shock syndrome Thrombocytopenia Anaphylaxis  Fever≥38°C  Other (specify)................................................................ | Date AEFI started **:** \_ \_ / \_ \_ / \_ \_  Time  Describe AEFI (Signs & Symptoms): |
| ***\*Serious: Yes / No;* **IfYes Death Lifethreatening Persistent orsignificantdisability Hospitalization Congenital anomaly Other important medical event(specify).................................................................................................  ***\*Outcome:*** Recovering Recovered Recoveredwithsequela Not Recovered Unknown  Died If Died, date of death : \_ \_ / \_ \_ /\_ \_ Autopsydone: Yes No Unknown | |
| 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: | |

First Decision making level to complete:

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| Investigation needed: Yes No | If Yes, date investigation planned : \_ \_ / \_ \_ / \_ \_ |

National level to complete:

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| Date report received at National level \_ \_ / \_ \_ / \_ \_ | AEFI worldwide unique ID **:** |
| Comments: | |

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