IMMUNIZATION

Adverse Event Following Immunization (AEFI)

Reset Form

Provincial Public Health Information System PPHIS

Personal Details

Last Name: _____ **First Name:** _____ **Client ID:** _____

DOB (yyyy/mm/dd)**:** _____ **Gender:** _____ **Health Card No:** _____

Address: _____ **Phone No:** _____

_____

IMPACT Local Inventory Number (LIN): _____

Organization: _____ **SDL:** _____

Report events which have a temporal association with a vaccine and which cannot be clearly attributed to other causes. A causal relationship does not need to be proven, and submitting a report does not imply causality. Of particular interest are those AEFIs which meet one or more of the following criteria:
a) Is of a serious nature, b) Requires urgent medical attention, c) Is an unusual or unexpected event

*Reporting Source

***Reporter:** **Date Reported:** _____

Setting: ☐ Hospital ☐ Pharmacy ☐ Physician Office ☐ Public Health ☐ Workplace Health ☐ Other _____

Provider who is in the index: ☐ Enter info below **Provider who is non-indexed:** ☐ Enter info below

***Last Name:** _____ ***First Name:** _____

***Email Address:** _____ ***Or Phone:** _____

***Address:** _____

City: _____ **Province/Territory:** _____

Postal Code: _____ **Professional Status:** _____

***Source of Information:** ☐ Client ☐ Same as Reporter ☐ Other

*Immunization Data

Selected Immunization: _____ **Immunization Date:** _____ **Dose #** ____ **Lot #** _____

Selected Immunization: _____ **Immunization Date:** _____ **Dose #** ____ **Lot #** _____

Selected Immunization: _____ **Immunization Date:** _____ **Dose #** ____ **Lot #** _____

Selected Immunization: _____ **Immunization Date:** _____ **Dose #** ____ **Lot #** _____

Selected Immunization: _____ **Immunization Date:** _____ **Dose #** ____ **Lot #** _____

*Information at Time of Immunization and AEFI Onset

Breastfeeding at time of immunization?

☐ No ☐ Unknown ☐ Yes (provide details)

Comments: _____

_____

Pregnant at time of immunization?

☐ No ☐ Unknown ☐ Yes If yes, gestation: Weeks: _____ Days: _____

Comments: _____

_____

Client ID: _____

Did an AEFI follow a previous dose of any of the above immunizing agents?

☐ No ☐ No Prior Dose ☐ Unknown ☐ Yes (provide details)

Comments: _____

Did this AEFI follow an incorrect immunization?

☐ No ☐ Unknown ☐ Yes (provide details)

Comments: _____

Medical history (up to the time of AEFI onset): (check all that apply and provide details for each.)

☐ Concomitant medication(s), including prescription, over the counter, herbal supplements, and traditional medicines

☐ Known medical conditions (e.g. immunocompromised, chronic conditions, including those with intermittent symptoms

☐ Acute illness/injury ☐ Prior COVID-19 infection: Date: _____ Test Type: _____

☐ No known medical condition(s) ☐ Unknown at time of report

Comments: _____

*AEFI Details

Local reaction at or near injection site

***Onset:** mins _____ hours _____ days _____

***Duration:** Mins _____ hours _____ days _____ ☐ Unresolved

Reactions:

☐ Infected abscess (MD) ☐ Sterile abscess (MD) ☐ Cellulitis (MD) ☐ Nodule ☐ Reaction stretches joint-to-joint

☐ Rash ☐ Adenopathy/Lymphadenitis (MD) ☐ Pain, redness, or swelling extends past the nearest joint

☐ Pain or redness or swelling persisting 10 days or more ☐ Other, specify

Comments: _____

For any injection site reaction indicated above, check all that apply below and provide details in the comments area in this section:

Descriptors:

☐ Swelling ☐ Pain ☐ Tenderness ☐ Erythema ☐ Warmth ☐ Induration

Client ID: _____

Descriptors (cont):

☐ Largest diameter of injection site reaction (cm): _____ ☐ Site(s) of reaction _____

☐ Palpable fluctuance ☐ Fluid collection shown by imaging technique (e.g. MRI, ultrasound) ☐ Spontaneous / surgical drainage

☐ Microbial results, specify in comments ☐ Lymphangitic streaking ☐ Regional lymphadenopathy

Comments: _____

_____

_____

Anaphylaxis or Other allergic events:

Event Type: ☐ Anaphylaxis ☐ Oculo-Respiratory Syndrome (ORS) ☐ Other allergic events

***Onset:** mins _____ hours _____ days _____

***Duration:** Mins _____ hours _____ days _____ ☐ Unresolved

☐ **Epinephrine administered**

☐ **Skin/Mucosal**

❍ **GENERALIZED** ☐ At injection site ☐ Non-injection site ☐ Urticaria ☐ Erythema
☐ Pruritus ☐ Prickle sensation ☐ Rash

❍ **LOCALIZED** ☐ At injection site ☐ Non-injection site ☐ Urticaria ☐ Erythema
☐ Pruritus ☐ Prickle sensation ☐ Rash

❍ **EYES** ☐ Red Bilateral ☐ Red Unilateral ☐ Itchy

❍ **ANGIOEDEMA** ☐ Tongue ☐ Throat ☐ Uvula ☐ Larynx
☐ Lip ☐ Eyelids ☐ Face ☐ Limbs
☐ Other, specify _____ ☐ Reported sensation of swelling ☐ Visible swelling

☐ **Respiratory** ☐ Sneezing ☐ Rhinorrhea ☐ Hoarse voice ☐ Sensation of throat closure
☐ Stridor ☐ Dry cough ☐ Tachypnea ☐ Wheezing
☐ Increased use of accessory muscles ☐ Grunting ☐ Cyanosis ☐ Sore throat
☐ Indrawing / retractions ☐ Difficulty swallowing ☐ Chest tightness ☐ Difficulty breathing

☐ **Cardio-vascular** ☐ Measured hypotension ☐ Decreased central pulse volume ☐ Capillary refill time >3 seconds
☐ Tachycardia ☐ Decreased or loss of consciousness

☐ **Gastrointestinal** ☐ Diarrhea ☐ Abdominal pain ☐ Nausea ☐ Vomiting

Comments: _____

_____

_____

Client ID: _____

Neurologic event

***Onset:** mins _____ hours _____ days _____

***Duration:** mins _____ hours _____ days _____ ☐ Unresolved

Reactions:

☐ Seizure(s) (check all that apply)

☐ Febrile ☐ Afebrile ☐ Unknown type ☐ Focal / Partial

☐ Generalized

❍ Tonic ❍ Clonic ❍ Tonic-Clonic ❍ Atonic ❍ Myoclonic ❍ Absence

☐ Witnessed by healthcare professional? ❍ Yes ❍ No ❍ Unknown

☐ Sudden loss of consciousness? ❍ Yes ❍ No ❍ Unknown

☐ Previous history of seizures ❍ Febrile ❍ Afebrile ❍Unknown type

☐ **Meningitis** (MD)

☐ **Encephalopathy/Encephalitis** (MD)

☐ **Guillain-Barre Syndrome (GBS)** (MD)

☐ **Bell's Palsy** (MD)

☐ **Myelitis / Transverse myelitis** (MD)

☐ **Subacute sclerosing panencephalitis** (MD)

☐ **Other Paralysis** (MD)

☐ **Other neurologic diagnosis, specify** (MD)

_____

☐ **Anaesthesia / Paraesthesia:**

☐ Generalized ☐ Localized ☐ Numbness ☐ Tingling ☐ Burning

☐ Formication ☐ Other, specify: _____

Descriptors:

☐ Depressed/altered level of consciousness, lethargy or personality change lasting >= 24hrs

☐ Focal or multifocal neurologic sign(s)

☐ Fever (>=38.0C)

☐ CSF abnormality

☐ EEG abnormality

☐ EMG abnormality

☐ Neuroimaging abnormality

☐ Brain / spinal cord histopathologic abnormality

Comments: _____

Other events

***Onset:** mins _____ hours _____ days _____

***Duration:** Mins _____ hours _____ days _____ ☐ Unresolved

Reactions:

☐ **Hypotonic-Hyporesponsive Episode** (MD)

☐ Limpness ☐ Pallor/cyanosis ☐ Reduced responsiveness/unresponsiveness

☐ **Persistent crying (crying which is continuous and unaltered for >= 3hrs)**

☐ **Rash** (Non-allergenic)

☐ Generalized ☐ Localized at non-injection site

☐ **Intussusception** (MD)

☐ **Hematochezia** (MD)

Client ID: _____

☐ **Arthritis** (MD)

☐ Joint redness ☐ Joint warm to touch ☐ Joint swelling ☐ Inflammatory changes in synovial fluid

☐ **Parotitis** (MD)

☐ **Orchitis** (MD)

☐ **Kawasaki disease** (MD)

☐ **Thrombocytopenia** (MD)

☐ Platelet count <150 x 10^9/L ☐ Petechial rash ☐ Other clinical evidence of bleeding

☐ **Thrombosis**

☐ **Thromboembolism**

☐ **Fever >= 38.0C**

☐ **Syncope with injury**

☐ **Severe vomiting**

☐ **Severe diarrhea**

☐ **Myocarditis and/or Pericarditis**

☐ **Other serious or unexpected event(s) not listed above, specify**

_____

_____

Impact of AEFI, Outcome and level of care

Highest impact of AEFI: ☐ Did not interfere with daily activities ☐ Interfered with but did not prevent daily activities ☐ Prevented Daily activities

Outcome at time of report: ☐ Fatal: Date of death:_____ ☐ Fully recovered ☐ Not yet recovered

☐ Permanent Disability/Incapacity ☐ Unknown

Medical Attention

Highest level of care required: ☐ Admitted to hospital ☐ Emergency visit ☐ Non urgent visit to a health professional ☐ None

☐ Resulted in prolongation of existing hospitalization ☐ Telephone advice from a health professional ☐ Unknown

Complete below where applicable:

Date of admission _____ **Date of discharge** _____

Days spent in hospital due to adverse event _____

Treatment received: ☐ No ☐ Unknown ☐ Yes (provide details of all treatments, including self treatment)

Comments: _____

Public Health Recommendations

AEFI Status: ☐ Submitted for review ☐ Review complete **Last Review Date:** _____ **Eligible for reporting to PHAC:** ☐

Reviewer ☐ On behalf of Health Service Provider **Provider Name:** _____

Public Health Recommendations ☐ No change to immunization schedule ☐ Expert referral, specify _____

☐ Determine protective antibody level ☐ Controlled setting for next immunization

☐ No further immunizations, specify _____

☐ Active follow-up for AEFI recurrence after next vaccine

☐ Other, specify _____

☐ No recommendations

Comments: _____

Document Management

File name: _____ **Document Title:** _____

Effective Date: _____ **Status:** _____

Supplementary Information

Comments: _____

_____

_____