



Vaccine Safety Provider Reporting Form For ADVERSE EVENT FOLLOWING IMMUNISATION

Please forward completed form to the Immunisation Section, Communicable Disease Control Branch by:
Fax (08) 82267197 or mail: PO Box 6 Rundle Mall ADELAIDE SA 5000 or email cdbc@health.sa.gov.au.
Alternatively you may call the Immunisation Section on 1300 232 272 and a nurse will take a Phone Report.

IMMUNISATION SECTION OFFICE USE ONLY

Admin Received:/...../.....

EVENT ID

Date: ____ / ____ / ____

REPORTER DETAILS

Reporter Type: GP Council Community Health Aboriginal Health
 Hospital Aged Care Facility Parent via Parent Helpline
 Other (please specify) _____

Title: _____ First Name _____ Surname _____

Organisation Name _____ Phone _____

VACCINEE DETAILS

First Name _____ Surname _____ DOB ____ / ____ / ____

Postal Address _____ Suburb _____ Postcode _____

Phone(s) _____ Sex Male Female

Aboriginal Torres Strait Islander

Parent/Caregiver Details (if applicable)

First Name _____ Surname _____

Contact Ph Number(s) _____

IMMUNISATION PROVIDER

(if different from above)

Who provided the vaccine? Doctor Nurse/Midwife Health Worker

Location GP Council Community Health Aboriginal Health
 Hospital Aged Care Facility School Other (please specify)

Organisation/Clinic Name _____ Contact Ph Number _____

Address _____ Suburb _____ Postcode _____

MEDICAL HISTORY

Other vaccines or medications in last 4 weeks? Yes No Unknown
 Illness at time of vaccination? Yes No Unknown
 Pre-existing Medical Conditions/Allergies? Yes No Unknown

Only if aged under 5 years

Gestation _____ weeks
 Birth weight _____ grams

Details

VACCINES ADMINISTERED

Date of Vaccination ____ / ____ / ____ Time (24 hr clock) _____

Vaccine Antigen (s)	Vaccine Brand	Dose	Batch No.	Site
				LL / RL / LA / RA / O / IN / UK
				LL / RL / LA / RA / O / IN / UK
				LL / RL / LA / RA / O / IN / UK
				LL / RL / LA / RA / O / IN / UK
				LL / RL / LA / RA / O / IN / UK

** LL = Left Leg; RL = Right Leg; LA = Left Arm; RA = Right Arm; O = Oral; IN = Intranasal; UK = Unknown.

Injection Site Reaction	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Reaction site: LL / RL / LA / RA	Time to onset of symptoms _____
Onset Date _____ / _____ / _____	Onset Time _____ (24 hr clock)		
<input type="checkbox"/> Rash	<input type="checkbox"/> at/near injection site/limb ONLY		
<input type="checkbox"/> Pain	<input type="checkbox"/> around INJECTION SITE ONLY <input type="checkbox"/> restricting LIMB MOBILITY		
<input type="checkbox"/> Swelling	<input type="checkbox"/> around INJECTION SITE ONLY <input type="checkbox"/> TO nearest joint <input type="checkbox"/> from JOINT to JOINT <input type="checkbox"/> BEYOND the nearest joint		
<input type="checkbox"/> Limb Swelling	<input type="checkbox"/> more than TWICE normal width		
<input type="checkbox"/> Other	Please specify: _____	Status	<input type="checkbox"/> Recovered <input type="checkbox"/> Not Recovered <input type="checkbox"/> Unknown
Outcome	Duration of Symptoms _____	Recovery Date	_____ / _____ / _____

General Reaction	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Time to onset of symptoms _____
Outcome	Duration of Symptoms _____	Onset Date _____ / _____ / _____
Status	<input type="checkbox"/> Recovered <input type="checkbox"/> Not Recovered <input type="checkbox"/> Unknown	Onset Time _____ (24 hr clock)
Details:	Recovery Date _____ / _____ / _____	

TREATMENT DETAILS
Type of Treatment <input type="checkbox"/> Parental Only <input type="checkbox"/> Self <input type="checkbox"/> Parent Helpline <input type="checkbox"/> GP Assessment <input type="checkbox"/> Hospital Emergency Assessment
<input type="checkbox"/> Hospital Admission days <input type="checkbox"/> Other (please specify) _____ <input type="checkbox"/> Unknown
Name/Organisation/contact details _____
Details of Treatment _____

CONSENT
I, the undersigned, hereby give consent for Immunisation Section, Communicable Disease Control Branch to:
• Contact me and/or the Immunisation Provider listed above about the vaccine safety report. <input type="checkbox"/> Yes <input type="checkbox"/> No
• Contact me with information about participating in Immunisation Research. <input type="checkbox"/> Yes <input type="checkbox"/> No
Name: _____ Signature _____ Date: _____ / _____ / _____
If the report was taken by telephone, verbal consent was obtained on behalf of the vaccinee / parent by:
Name: _____ Signature _____ Date: _____ / _____ / _____
Organisation _____ Date: _____ / _____ / _____

IMMUNISATION SECTION OFFICE USE ONLY - INTERNAL ASSESSMENT					
<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Bradycardia	<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Headache	<input type="checkbox"/> Nausea	<input type="checkbox"/> Shock
<input type="checkbox"/> Abscess	<input type="checkbox"/> Chest tightness	<input type="checkbox"/> Drowsy	<input type="checkbox"/> Hives	<input type="checkbox"/> Neck stiffness	<input type="checkbox"/> Skin Rash (unspecified)
<input type="checkbox"/> Angioedema	<input type="checkbox"/> Conjunctivitis	<input type="checkbox"/> Erythema/Flushing	<input type="checkbox"/> Hyporesponsive	<input type="checkbox"/> Pallor	<input type="checkbox"/> Sore Throat
<input type="checkbox"/> Anorexia	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Fever (<40c)	<input type="checkbox"/> Hypotonia	<input type="checkbox"/> Parotid Swelling	<input type="checkbox"/> Urticarial rash/Welts
<input type="checkbox"/> Apnoea	<input type="checkbox"/> Coryza	<input type="checkbox"/> Fever (>40c)	<input type="checkbox"/> Irritability	<input type="checkbox"/> Photophobia	<input type="checkbox"/> Vomiting
<input type="checkbox"/> Arthralgia	<input type="checkbox"/> Cough	<input type="checkbox"/> Fever (unrecorded)	<input type="checkbox"/> Itch	<input type="checkbox"/> Screaming	<input type="checkbox"/> Wheeze
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diarrhoea	<input type="checkbox"/> Flu-like symptoms	<input type="checkbox"/> Lethargy/Malaise	<input type="checkbox"/> Seizure	
<input type="checkbox"/> Other (please describe)					
<input type="checkbox"/> Certain	<input type="checkbox"/> Probable	<input type="checkbox"/> Possible	<input type="checkbox"/> Unclear	<input type="checkbox"/> Not Related	

IMMUNISATION SECTION OFFICE USE ONLY	ADRAC <input type="checkbox"/> Yes <input type="checkbox"/> No
Notes	Sent _____ / _____ / _____
	SIS Clinic? <input type="checkbox"/> Yes <input type="checkbox"/> No
Letter <input type="checkbox"/> No Contact <input type="checkbox"/> No Contact - SIS Referral <input type="checkbox"/> Std Letter No ADRAC <input type="checkbox"/> Std Letter ADRAC	Sent _____ / _____ / _____