BC Centre for Disease Control
Provincial Health Services Authority

# Report of Adverse Event Following Immunization

**Dear Doctor / Pharmacist / Health Care Provider:**

Complete this report on a person who has received immunization and experiences an event that required medical attention, was unusual or unexpected, was serious (hospitalization, residual disability, life threatening, fatal outcome) and was suspected to be related to the vaccine. Unusual clusters or high frequency of events should also be reported to your medical health officer / local health unit (by phone/ fax/ email). For details, see CD Manual. Chapter 2. Immunization. Part 5. Adverse Events Following Immunization.
Save and email or print and fax the completed report to your local or regional health unit as listed here: https://bit.ly/3gbbnT2
Email completed form from a regional health authority account. Emailing from other accounts (e.g., shaw, telus, gmail, etc.) is not secure.

## PATIENT INFORMATION

| Last Name | First Name | Middle Name(s) |
|---|---|---|
| | | |

| Date of Birth (YYYY / MM / DD) | Health Card Number (PHN) | Gender |
|---|---|---|
| | | ☐ Female ☐ Male ☐ Undifferentiated ☐ Unknown |

| Phone No. | Alt. Phone Number | Email |
|---|---|---|
| | | |

| Address: Unit # | Street # | Street Name | City |
|---|---|---|---|
| | | | |

| Postal Code | Province | Country of Residence (if outside of Canada) |
|---|---|---|
| | | |

## MEDICAL HISTORY

Current medications ☐ Yes ☐ No ☐ Unknown
If yes, specify:

Known medical conditions ☐ Yes ☐ No ☐ Unknown
If yes, specify:

Known allergies ☐ Yes ☐ No ☐ Unknown
If yes, specify:

## IMMUNIZATION DATA

| Vaccine name | Date vaccine administered (YYYY / MM / DD) | Lot# | Dose# | Dosage (ml) | Route | Site |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

## IMPACT OF AEFI, OUTCOME, AND LEVEL OF CARE OBTAINED

**Highest impact of AEFI** *(Choose one of the following):*

☐ Did not interfere with daily activities ☐ Interfered but did not prevent daily activities ☐ Prevented daily activities

**Outcome at time of report** *(Choose one of the following):*

☐ Permanent disability/incapacity ☐ Fully recovered ☐ Not yet recovered
☐ Unknown ☐ Death, specify date: YYYY MM DD

**Highest level of care obtained** *(Choose one of the following):*

☐ Emergency visit ☐ Non-urgent visit ☐ Telephone advice from a health professional ☐ None ☐ Unknown
☐ Admitted to hospital ( days) **OR** ☐ Resulted in prolongation of existing hospitalization (by days)

| Hospital Name: | Hospital Admission Date: YYYY MM DD | Hospital Discharge Date: YYYY MM DD |
|---|---|---|
| | | |

**Treatment received:**

☐ No ☐ Unknown ☐ Yes

Provide details of treatment, including self-treatment:

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## ADVERSE EVENT

Time to Onset must be recorded as **number** of minutes, hours or days / Duration of event must be recorded as **number** of minutes, hours, days or unresolved

| | Time to Onset in Number | | | Duration in number | | | |
|---|---|---|---|---|---|---|---|
| | Mins or | Hrs or | Days | Mins or | Hrs or | Days | Unresolved |
| **Local reactions at or near injection site** | | | | | | | |
| Infected Abscess | | | | | | | |
| Sterile Abscess | | | | | | | |
| Cellulitis | | | | | | | |
| Nodule | | | | | | | |
| Pain/redness/swelling past joint | | | | | | | |
| Pain/redness/swelling ≥10 days | | | | | | | |
| Adenopathy/Lymphadenitis | | | | | | | |
| Rash at Injection Site | | | | | | | |
| **Allergic reactions** | | | | | | | |
| Anaphylaxis | | | | | | | |
| Allergic reaction (non-anaphylaxis) | | | | | | | |
| Oculo-Respiratory Syndrome (ORS) | | | | | | | |
| **Neurological events** | | | | | | | |
| Seizures | | | | | | | |
| Anesthesia/Paresthesia | | | | | | | |
| Meningitis | | | | | | | |
| Encephalopathy/Encephalitis | | | | | | | |
| Guillain-Barré Syndrome | | | | | | | |

| | Time to Onset in Number | | | Duration in Number | | | |
|---|---|---|---|---|---|---|---|
| | Mins or | Hrs or | Days | Mins or | Hrs or | Days | Unresolved |
| **Neurological events cont'd** | | | | | | | |
| Bell's Palsy | | | | | | | |
| Myelitis / Transverse Myelitis | | | | | | | |
| Other paralysis | | | | | | | |
| Other Neurological – specify: | | | | | | | |
| **Other events of interest** | | | | | | | |
| Arthritis | | | | | | | |
| Persistent Crying (≥3 hours) | | | | | | | |
| Hypotonic-Hyporesponsive Episode (<2 years old) | | | | | | | |
| Thrombocytopenia (plt<150x$10^9$/L) | | | | | | | |
| Syncope with injury | | | | | | | |
| Myocarditis/Pericarditis | | | | | | | |
| Rash **(non-injection site)** requiring MD | | | | | | | |
| Vomiting/diarrhea *(≥3x in 24 hours)* | | | | | | | |
| Other severe or unusual – specify: | | | | | | | |

## COMMENTS FURTHER DESCRIBING ADVERSE EVENT(S)

## REPORTER INFORMATION

Last Name First Name ☐ MD ☐ Pharmacist ☐ RN ☐ NP ☐ Other

Phone No. Ext. Fax No.

Email Date reported to public health YYYY MM DD

Setting:

☐ Physician office ☐ Hospital ☐ Pharmacy ☐ Health Authority Workplace Health

☐ Other, specify: