ADVERSE EVENTS FOLLOWING IMMUNISATION REPORTING FORM

For all events including suspected anaphylaxis

PATIENT Details SAR2009v5

Surname:	**First Name(s)**	**NHI No:**
		XXX9999
Address:		**Date of Birth:**
		Sex: ☐**M** ☐**F**

VACCINES - ASTERISK SUSPECT VACCINE(S)

Vaccine(s)	**Batch No:**	**Dose**	**Route And Site**	**Date Given**	**Time Given**	**Reason for Use**

ALL CONCOMITANT MEDICINES IN USE

Medicine(s)	**Dose**	**Route**	**Date Started**	**Date Stopped**	**Reason for Use**

DESCRIPTION OF ADVERSE REACTION

Date of Onset: dd/mm/yy: **Time of Onset:**

Please describe reaction here:

Treatment Given:……

Other Exposure possible to account for the event:……..

Previous AEFI: ☐ **Yes** ☐ **No** **Details: ……**

Clinical Obs: Pulse:_____ BP: _____ Temperature: _____ Other: _____

Serum Tryptase: _____

Description of Outcome of Adverse Reaction or Incident

Recovered ☐ Not yet recovered ☐ Unknown ☐ Fatal ☐ Date of Death

Severe ? **Yes** ☐ **N**o ☐ **Rechallenge ?** **N**o ☐ **Y**es ☐ Result:

OTHER FACTORS - Please circle

Renal Disease	☐	Hepatic Disease	☐	Allergy ☐	Describe:
OTC Use?	☐	Industrial Chemicals	☐	Past Medical Hx / Other Medical Conditions?	☐

REPORTER :

Name: Telephone:

Address:

Email address?: Date:

Post to: Freepost 112002, Centre for Adverse Reactions Monitoring, PO Box 913, **DUNEDIN** **or** Fax to: (03)-479-7150