Reporting Form for Adverse Events Following Immunization

The attached Adverse Event Following Immunization Form developed by Alberta Health (AH) is for use by Alberta Immunization Providers. Immunizers should follow processes specific to each zone for AEFI reporting and follow-up.

The attached form can be found on the AH website at the following web link:
http://www.health.alberta.ca/professionals/immunization-policy.html

Zone Contact Information for AEFI:

The following is contact information for questions related to the reporting and follow-up of AEFI for any provincially funded vaccines or vaccine purchased by AHS Public Health Programs.

North Zone:
CDC Intake
Fax: 1-855-532-4373
Phone: 1-855-513-7530

Edmonton Zone:
Immunization Team
Fax: 780-342-0248
Phone: 780-342-0229

Central Zone:
Communicable Disease Control
Fax: 403-356-2053
Phone: 403-356-6420

Calgary Zone:
Communicable Disease Unit
Fax: 403-955-6755
Phone: 403-955-6750

South Zone:
Public Health Nursing Team
Fax: 403-380-2893
Phone: 403-388-6684

AEFI Form Instructions for Use:

1. **Demographic Information:**
   Complete **ALL** demographic information.
   a. RHA (Regional Health Authority) Number - the number of the Zone submitting the report.
      - North: Zone 5
      - Edmonton: Zone 4
      - Central: Zone 3
      - Calgary: Zone 2
      - South: Zone 1
   b. Delivery Management Site - the name or number of the Public Health Centre/Unit submitting the report
   c. Report Date - date on which the form is completed.
   d. LIN Number - an IMPACT Local Inventory Number (LIN) is to be assigned by the IMPACT Nurse monitor when an AEFI report is generated from an IMPACT centre. The IMPACT LIN is used to link the initial provincial/territorial AEFI report to the IMPACT report. Once both reports have been received, the data contained on the AEFI form and the IMPACT forms are merged in the CAEFISS database.
   e. Parent/Guardian Names - ensure names are current.

2. **Medical History:** Check appropriate boxes.

3. **Immunization Information:**

   a. Date of Immunization - date that the vaccine (s) temporally related to the adverse event was/were given.
      List **all** vaccines given on the day identified as the date of immunization.
      - Information for a maximum of 5 immunizing agents administered on the same visit can be included on the form.
      - In the rare event that 6 or more agents are administered, the additional information is to be included on a separate page(s) using progress notes and attached to the AEFI form.
      - Number the attached page(s), numbering the first attached page as "page 2".
      - Ensure that the client's name and birth date are at the top of the additional sheet
      - Do NOT add another AEFI form.
   b. Time of Immunization - time that the vaccine(s) temporally related to the adverse event was/were given
   c. Vaccine Code - located in the specific AHS vaccine biological page. Do not use trade names (e.g., Infanrix- IPV- Hib).
   d. Manufacturer - enter the manufacturer's name for each of the immunizing agents. Manufacturer is listed in the specific AHS vaccine biological page
   e. Lot Number - record lot number as it appears on the vaccine box, vial, ampoule or preloaded syringe.
   f. No. in Series - enter the actual number of the dose given. (i.e., 1, 5, 8).
      - Do not use the term booster when describing the dose number (e.g., MMR-Var after MMR is dose 2).
      - If number in series is unknown, leave the space blank
   g. Dosage - use "**mL**", not 'cc' when recording the dose of the immunizing agent.
   h. Route - use the following abbreviations to describe route of administration:

ID	Intradermal	IM	Intramuscular
PO	Oral	SC	Subcutaneous
IN	Intranasal		

i. Site - use the following abbreviations to describe site:

R	Right	L	Left
A	Arm	L	Leg
G	Gluteal	MO	Mouth
MS	Multiple sites	NO	Nose
U*	Upper	L*	Lower
F*	Forearm		

e.g., to indicate that the right arm was used, enter RA

If the site used is not listed, state reason in the "Description of Event" section.

*Dependent on selections available in the electronic systems. Should be included in paper forms when used.

4. Reportable Adverse Events:

a. Report all serious and unexpected events following immunization that meet the criteria for each category as listed in the AH Adverse Events Following Immunization (AEFI) Policy for Alberta Immunization Providers.

b. Report the onset interval and the duration for each specific event reported. The onset and duration intervals are to be reported in minutes (M), hours (H) or days (D)

E.g., fever (#1) of 39 ºC started 8 hours after immunization and resolved within 48 hours, convulsion/seizure (#9) started 12 hours after immunization and resolved within 24 hours. You would enter information as follows:

Adverse Event	Onset			Duration		
	M	H	D	M	H	D
1 ☒ Fever __39_ Cº		8			48	
9 ☒ Convulsions/Seizures		12			24	

c. For those categories requiring diagnosis by a physician, attach supporting documentation such as laboratory reports, summary notes, etc.

5. Description of Event:

Provide specific information that is not captured by the categories in this section. Information should apply to the reaction ONLY.

- Documentation of attempted phone calls, conversations with the client, etc. should be included in the progress notes on the client's file but are **not** to be included with the AEFI report.
- If a physician was consulted or the client was seen in ER or hospitalized, please provide the full name of same.
- If the space is insufficient, attach a separate page (progress notes). Do not add another adverse events following immunization form.
  - Ensure that the client's name and birth date are at the top of the additional sheet and number the pages
- Do not use days of the week but actual dates (e.g., October 23)

6. **Level of Care Received:**
   Check appropriate boxes. If hospitalized complete date of admission and discharge.

7. **Treatment:**
   Check appropriate box. If treatment received, check appropriate boxes.

8. **Outcome of Events:**
   Check appropriate box. If final outcome is expected within a 2 week interval, keep AEFI report until this information is available, e.g., local reactions. If outcome is still pending at 2 weeks following initial report, submit the original report and send an update when final outcome is known. If unable to contact client to complete AEFI submit with outcome of "Lost to follow up".

9. **Reporter Name:**
   - Print the initial and surname of the person completing/submitting the AEFI form.
   - Check designation.
   - Sign name and provide phone number

10. **Regional Recommendations and Comments:**
    This section will be completed as per zone process.

Alberta Government

Report of Adverse Events Following Immunization

☐ Initial Report ☐ Updated Report | **Shaded areas are not reported electronically.** | AEFI# | For Alberta Health Only

RHA Number (Reporting RHA)	Delivery Management Site	Personal Health Number	Report Date *(yyyy-mm-dd)*	LIN Number

Client Name *(Last)*	*(First)*	*(Middle)*	Gender ☐ Male ☐ Female ☐ Unknown	Date of Birth *(yyyy-mm-dd)*

Client Address	Parent/Guardian

City	Province	Postal Code	Phone Number

Medical History:

Current Medications: ☐ Yes ☐ No ☐ Unknown If yes specify:

Known Medical Conditions: ☐ Yes ☐ No ☐ Unknown If yes specify:

History of allergies: ☐ Yes ☐ No ☐ Unknown If yes specify:

Previous Adverse Event to Immunization: ☐ Yes ☐ No ☐ Unknown If yes specify:

History of Convulsions: ☐ Yes ☐ No ☐ Unknown

Immunization Information | Date of Immunization *(yyyy-mm-dd)*: | Time of Immunization:

Vaccine Code	Manufacturer	Lot #	No. in Series	Dosage	Route	Site

Adverse Event	Onset M	Onset H	Onset D	Duration M	Duration H	Duration D
1 ☐ Fever ____ C°						
2 ☐ Infective Abscess (attach lab results)						
4 ☐ Pain and/or Swelling						
6 ☐ Screaming Episode/Persistent Crying						
9 ☐ Convulsions/Seizures						
12 ☐ Anaesthesia/paraesthesia*						
13 ☐ Paralysis*						
14 ☐ Guillain-Barré Syndrome*						
15 ☐ Subacute Sclerosing Panencephalitis (SSPE)*						
16 ☐ Adenopathy (provide location)						
17 ☐ Anaphylaxis						
18 ☐ Allergic Reaction (provide description)						
20 ☐ Erythema Multiforme*						
21 ☐ Rash (provide description)						
22 ☐ Hypotonic Hyporesponsive Episode						

Adverse Event	Onset M	Onset H	Onset D	Duration M	Duration H	Duration D
27 ☐ Arthralgia/Arthritis (provide location)						
28 ☐ Severe Diarrhea and/or Vomiting						
29 ☐ Parotitis*						
30 ☐ Orchitis*						
31 ☐ Thrombocytopenia*(attach lab results)						
33 ☐ Cellulitis*						
34 ☐ Sterile Abscess						
35 ☐ Nodule						
36 ☐ Encephalitis, ADEM, Myelitis*						
37 ☐ Meningitis*						
38 ☐ Oculo-Respiratory Syndrome (ORS)						
39 ☐ Bell's Palsy*						
40 ☐ Intussusception*						
32 ☐ Other Unusual Events						

Must be diagnosed by a physician, Please Provide Details

Description of Event:

Level of Care Received
- ☐ Advice from a Health Professional
- ☐ Emergency room
- ☐ Required Hospitalization
  - Admission Date *(yyyy-mm-dd)*:
  - Discharge Date *(yyyy-mm-dd)*:

Treatment
☐ Yes ☐ No ☐ Unknown
If yes, indicate type of treatment:
Analgesic/Antipyretic
☐ Yes ☐ No ☐ Unknown
Epinephrine
☐ Yes ☐ No ☐ Unknown
Antihistamine
☐ Yes ☐ No ☐ Unknown
Other (specify):

Outcome of Events
- ☐ Client fully recovered
- ☐ Permanent disability/incapacity
- ☐ Death
- ☐ Lost to follow-up
- ☐ Not yet recovered
- ☐ Unknown

Reporter Name:	Signature:	Phone Number:
Reporter Designation: ☐ RN ☐ MD ☐ LPN ☐ NP ☐ PHARM ☐ OTH		

Regional Recommendations

☐ Change to immunization schedule ☐ CMOH Advice Requested ☐ No further immunization. Specify:

☐ Expert Referral (specify type): ☐ Other (specify):

Comments

Print Name (MOH/Designate):	Signature:	Phone Number:
		Date Reported *(yyyy-mm-dd)*:

CD0808 (2014/01) ☐ Enhanced reporting form attached

Page 1 of 1