Public Health Ontario | Santé publique Ontario

REPORT OF ADVERSE EVENT FOLLOWING IMMUNIZATION (AEFI)

When completed, please send the form to your local Public Health Unit by a secure means.
For more information about AEFI reporting in Ontario visit the Public Health Ontario website.

Case ID (for local use only)

1. CLIENT INFORMATION

Client last name	Given name(s)	Ontario Health Card #	Date of Birth (yyyy/mm/dd)	Gender
				☐ Male ☐ Female

Parent/guardian last name	Parent/guardian first name	Telephone no.

Address	City	Postal Code

Event reported by	Relationship with case

Reporting source contact information (If different from above)	Date of report (yyyy/mm/dd)

Form completed by	Contact information (if different from above)

2. IMMUNIZATION INFORMATION

Date / time (yyyy/mm/dd)	Agent/vaccine given	Manufacturer	Lot #	Exp. date (yyyy/mm/dd)	Dose #	Dosage/unit	Site	Route

Immunization error	Previous history of AEFI	Vaccine administered by
☐ No ☐ Unknown ☐ Yes* *Describe in Section 4	☐ No ☐ Unknown ☐ Yes* *Describe in Section 4	

3. ADVERSE EVENT (REACTION) INFORMATION

Report only events which cannot be attributed to co-existing conditions. Reactions marked with an asterisk (*) must be diagnosed by a physician. Record the **time to onset of the event** (time between vaccine administration and onset of each event) and the **duration** of each event in **minutes** or **hours** or **days**. If the interval / duration is less than one hour record in minutes, if less than 24 hours record in hours, if greater than or equal to 24 hours record in days.

LOCAL REACTION AT THE INJECTION SITE

	Time to onset of event (Specify minutes or hours or days)	Duration of event (Specify minutes or hours or days)
☐ Pain/redness/swelling extending past nearest joint		
☐ Pain/redness/swelling lasting 4 days or more		
☐ Infected abscess*		
☐ Sterile abscess*		
☐ Nodule		
☐ Cellulitis*		

SYSTEMIC REACTIONS

	Time to onset (Specify minutes or hours or days)	Duration of event (Specify minutes or hours or days)
☐ Fever greater than 38.0 °C (Only reportable in conjunction with another event)		
☐ Rash		
☐ Adenopathy / lymphadenopathy*		
☐ Hypotonic-hyporesponsive episode (HHE)*		
☐ Persistent crying / screaming		
☐ Severe vomiting / diarrhea (3 episodes/24 hours)		
☐ Parotitis*		

ALLERGIC REACTIONS

	Time to onset (Specify minutes or hours or days)	Duration of event (Specify minutes or hours or days)
☐ Event managed as anaphylaxis		
☐ Oculorespiratory syndrome (ORS)		
☐ Allergic reaction - skin (E.g. hives)		

NEUROLOGIC EVENTS

	Time to onset (Specify minutes, hours or days)	Duration of event (Specify minutes, hours or days)
☐ Convulsions / seizure		
☐ Encephalopathy / encephalitis*		
☐ Meningitis*		
☐ Anaesthesia / paraesthesia*		
☐ Paralysis*		
☐ Bell's Palsy*		
☐ Guillian-Barré Syndrome (GBS)*		
☐ Myelitis*/acute disseminated encephalomyelitis*		

OTHER EVENTS OF INTEREST

	Time to onset (Specify minutes or hours or days)	Duration of event (Specify minutes or hours or days)
☐ Thrombocytopenia*		
☐ Arthritis / arthralgia*		
☐ Intussusception*		
☐ Syncope (fainting) with injury		
☐ Other severe / unusual events		

Describe all events in Section 4 on reverse

4. COMMENTS FURTHER DESCRIBING THE ADVERSE EVENT(S)

Please provide a detailed description of the event including all signs and symptoms, medical history (e.g. immunocompromised, chronic illness/underlying medical conditions), concomitant medications, investigation, treatment, hospitalization details and description of previous history of AEFI or immunization error if indicated in Section 2.

5. HEALTH CARE UTILIZATION & OUTCOME

Please provide information about health care utilization related to the event. Outcome to be updated by the Public Health unit when the investigation is complete.

Medical consultation (non-urgent) ☐ Yes ☐ No Date (yyyy/mm/dd)

Seen in emergency department ☐ Yes ☐ No Date (yyyy/mm/dd)

Admitted to hospital because of event ☐ Yes ☐ No Admission date (yyyy/mm/dd)
Discharge date (yyyy/mm/dd)

Name and address of health professional attending the event

Name and address of facility where the event was attended to (e.g hospital name)

OUTCOME ☐ Recovered ☐ Not yet recovered (describe below) ☐ Permanent disability / incapacity (describe below) ☐ Unknown ☐ Death (describe below)

Date of outcome (yyyy/mm/dd)

6. MEDICAL OFFICER OF HEALTH (MOH) RECOMMENDATIONS

For Public Health Unit use only. To be completed by the MOH or designate.

Check all the apply

- ☐ No recommendation
- ☐ No change to immunization schedule
- ☐ Determine protective antibody levels (Specify)
- ☐ Active follow-up for AEFI recurrence after next vaccine
- ☐ Controlled setting for next immunization
- ☐ Expert referral (Specify)
- ☐ No further immunization (Contraindication or series complete - specify)
- ☐ Other (Specify)

MOH recommendation comments

Medical Officer of Health (MOH) or Designate

Name Signature Date (yyyy/mm/dd)

The personal health information provided on this form is collected under the authority of the *Health Protection and Promotion Act* and O. Reg 569 135/18. The personal health information is used to signal adverse events that may require more in-depth investigation and to ensure the continued safety of vaccines on the Canadian market by monitoring adverse events following immunization with vaccines. The information collected may be shared with the Public Health Agency of Canada. If you have questions about the collection of this personal health information please contact your local public health unit.

Updated April 2018