UNIQUE EPISODE NUMBER	IMPACT LIN

Manitoba
Health, Seniors and Active Living

REPORT OF ADVERSE EVENTS FOLLOWING IMMUNIZATION (AEFI)

I. CLIENT IDENTIFICATION

1. LAST NAME	2. FIRST NAME	
3. DATE OF BIRTH (YYYY - MM - DD)	4. SEX ◯ FEMALE ◯ MALE ◯ OTHER	5. HEALTH NUMBER (9 DIGITS)
6. ADDRESS		
7. POSTAL CODE (A#A #A#)	8. PROVINCE / TERRITORY	9. PHONE EXT. # (### - ### - ####)

II. REPORTER INFORMATION

10. SETTING
◯ PHYSICIAN OFFICE ◯ PUBLIC HEALTH ◯ HOSPITAL ◯ PHARMACY ◯ OTHER

11. LAST NAME	12. FIRST NAME	
13. ADDRESS		14. POSTAL CODE (A#A #A#)
15. PROVINCE / TERRITORY	16. PHONE EXT. # (### - ### - ####)	17. FAX (### - ### - ####)
18. DATE REPORTED (YYYY - MM - DD)	19. SIGNATURE	◯ MD ◯ RN ◯ IMPACT ◯ OTHER (SPECIFY):

III. SOURCE OF INFORMATION

◯ SAME AS REPORTER ◯ CLIENT ◯ OTHER (SPECIFY BELOW)

20. LAST NAME	21. FIRST NAME	22. RELATIONSHIP TO CLIENT
23. ADDRESS		MHSAL USE ONLY
24. POSTAL CODE (A#A #A#)	25. PROVINCE / TERRITORY	
26. PHONE EXT. #		

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IV. INFORMATION AT TIME OF IMMUNIZATION AND AEFI ONSET

27. **PROVINCE / TERRITORY OF IMMUNIZATION**

28. **DATE VACCINE ADMINISTERED**
(YYYY - MM - DD)

29. **TIME VACCINE ADMINISTERED**
(## : ##)
→ ○ AM ○ PM

IMMUNIZING AGENT	TRADE NAME	MANUFACTURER	LOT NUMBER	DOSE #	DOSAGE	UNIT	SITE	ROUTE

30. **DID AN AEFI FOLLOW A PREVIOUS DOSE OF ANY OF THE ABOVE IMMUNIZING AGENTS?**
○ NO ○ NO PRIOR DOSES ○ UNKNOWN ○ YES, PROVIDE DETAILS IN BOX 31.

31. **ADDITIONAL DETAILS** (ATTACH FURTHER COMMENTS ON A SEPARATE SHEET AND REFERENCE THIS BOX NUMBER)

32. **DID THIS AEFI FOLLOW AN INCORRECT IMMUNIZATION?**
○ NO ○ UNKNOWN ○ YES (IF YES, CHOOSE ALL THAT APPLY AND PROVIDE DETAILS IN BOX 33)

- ☐ GIVEN OUTSIDE THE RECOMMENDED AGE LIMITS
- ☐ DOSE EXCEEDED THAT RECOMMENDED FOR AGE
- ☐ INCORRECT ROUTE
- ☐ WRONG VACCINE GIVEN
- ☐ PRODUCT EXPIRED
- ☐ OTHER (SPECIFY):

33. **ADDITIONAL DETAILS** (ATTACH FURTHER COMMENTS ON A SEPARATE SHEET AND REFERENCE THIS BOX NUMBER)

34. **MEDICAL HISTORY UP TO THE TIME OF AEFI ONSET** (CHOOSE ALL THAT APPLY AND PROVIDE DETAILS IN BOX 35)
☐ CONCOMITANT MEDICATION(S) ☐ KNOWN MEDICAL CONDITIONS / ALLERGIES ☐ ACUTE ILLNESS / INJURY

35. **ADDITIONAL DETAILS** (ATTACH FURTHER COMMENTS ON A SEPARATE SHEET AND REFERENCE THIS BOX NUMBER)

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V. AEFI DETAILS

V.1. LOCAL REACTION AT OR NEAR VACCINATION SITE

36. **ONSET**	(MINUTES)	(HOURS)	(DAYS)	FROM IMMUNIZATION TO ONSET OF 1ST SYMPTOM OR SIGN	☐ UNRESOLVED
37. **DURATION**	(MINUTES)	(HOURS)	(DAYS)	FROM ONSET OF 1ST SYMPTOM / SIGN TO RESOLUTION OF ALL SYMPTOMS / SIGNS	

☐ INFECTED ABSCESS ☐ STERILE ABSCESS ☐ CELLULITIS ☐ NODULE

☐ REACTION CROSSES JOINT ☐ LYMPHADENITIS ☐ OTHER, (SPECIFY):

38. **ADDITIONAL DETAILS** (ATTACH FURTHER COMMENTS ON A SEPARATE SHEET AND REFERENCE THIS BOX NUMBER)

39. **FOR ANY INJECTION SITE REACTION INDICATED ABOVE, CHECK ALL THAT APPLY BELOW AND PROVIDE DETAILS IN THE COMMENTS AREA IN BOX 40.**

☐ SWELLING ☐ PAIN ☐ TENDERNESS ☐ ERYTHEMA ☐ WARMTH ☐ INDURATION ☐ RASH

☐ LARGEST DIAMETER OF VACCINATION SITE REACTION (SPECIFY): ➔	(CM)	☐ SITE(S) OF REACTION (SPECIFY): ➔	(e.g., LA, RA)

☐ PALPABLE FLUCTUANCE ☐ FLUID COLLECTION SHOWN BY IMAGING TECHNIQUE (E.G., MRI, CT, ULTRASOUND)

☐ SPONTANEOUS/SURGICAL DRAINAGE ☐ MICROBIAL RESULTS ☐ LYMPHANGITIC STREAKING ☐ REGIONAL LYMPHADENOPATHY

40. **ADDITIONAL DETAILS** (ATTACH FURTHER COMMENTS ON A SEPARATE SHEET AND REFERENCE THIS BOX NUMBER)

V.2. ANAPHYLAXIS OR OTHER ALLERGIC EVENTS

41. **ONSET**	(MINUTES)	(HOURS)	(DAYS)	FROM IMMUNIZATION TO ONSET OF 1ST SYMPTOM OR SIGN	☐ UNRESOLVED
42. **DURATION**	(MINUTES)	(HOURS)	(DAYS)	FROM ONSET OF 1ST SYMPTOM / SIGN TO RESOLUTION OF ALL SYMPTOMS / SIGNS	

43. **CHOOSE ONE OF THE FOLLOWING:** ◯ ANAPHYLAXIS ◯ OTHER ALLERGIC EVENTS

44. ☐ **SKIN / MUCOSAL**	◯ GENERALIZED	☐ AT INJECTION SITE ☐ NON-INJECTION SITE ☐ URTICARIA ☐ ERYTHEMA ☐ PRURITUS ☐ PRICKLE SENSATION
	◯ LOCALIZED	☐ AT INJECTION SITE ☐ NON-INJECTION SITE ☐ URTICARIA ☐ ERYTHEMA ☐ PRURITUS ☐ PRICKLE SENSATION
	EYES	☐ RED ☐ ITCHY
	ANGIOEDEMA	☐ TONGUE ☐ THROAT ☐ UVULA ☐ LARYNX ☐ LIP ☐ EYELIDS ☐ LIMBS ☐ OTHER, (SPECIFY):

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45. ☐ **CARDIO-VASCULAR**	☐ MEASURED HYPOTENSION	☐ ↓ CENTRAL PULSE VOLUME	☐ CAPILLARY REFILL TIME >3 SEC
	☐ TACHYCARDIA	☐ ↓ OR LOSS OF CONSCIOUSNESS	
46. ☐ **RESPIRATORY**	☐ SNEEZING	☐ RHINORRHEA	☐ HOARSE VOICE ☐ STRIDOR
	☐ DRY COUGH	☐ TACHYPNEA	☐ WHEEZING ☐ GRUNTING
	☐ CYANOSIS	☐ INDRAWING / RETRACTIONS	
	☐ SENSATION OF THROAT CLOSURE		
47. ☐ **GASTROINTESTINAL**	☐ DIARRHEA	☐ ABDOMINAL PAIN	☐ NAUSEA ☐ VOMITING

48. **ADDITIONAL DETAILS** (ATTACH FURTHER COMMENTS ON A SEPARATE SHEET AND REFERENCE THIS BOX NUMBER)

V.3. NEUROLOGIC EVENTS (ASTERISK (*) APPEARING NEXT TO A TERM INDICATES SPECIFIC EVENT THAT SHOULD BE DIAGNOSED BY A PHYSICIAN)

49. **ONSET**	(MINUTES)	(HOURS)	(DAYS)	FROM IMMUNIZATION TO ONSET OF 1ST SYMPTOM OR SIGN	☐ UNRESOLVED
50. **DURATION**	(MINUTES)	(HOURS)	(DAYS)	FROM ONSET OF 1ST SYMPTOM / SIGN TO RESOLUTION OF ALL SYMPTOMS / SIGNS	

51. ☐ **SEIZURE(S)** (CHECK ALL THAT APPLY)

- ☐ WITNESSED BY HEALTHCARE PROFESSIONAL ◯ YES ◯ NO ◯ UNKNOWN
- ☐ SUDDEN LOSS OF CONSCIOUSNESS ◯ YES ◯ NO ◯ UNKNOWN
- ◯ FOCAL
- ◯ GENERALIZED
  - ◯ TONIC ◯ CLONIC ◯ TONIC-CLONIC ◯ ATONIC ◯ ABSENCE ◯ MYOCLONIC
- ☐ PREVIOUS HISTORY OF SEIZURES
  - ◯ FEBRILE ◯ AFEBRILE ◯ UNKNOWN TYPE

52. ☐ **MENINGITIS***	53. ☐ **ENCEPHALOPATHY / ENCEPHALITIS***	54. ☐ **GUILLAIN-BARRE SYNDROME (GBS)***
55. ☐ **BELL'S PALSY***	56. ☐ **OTHER PARALYSIS***	

57. ☐ **OTHER NEUROLOGIC DIAGNOSIS*** ***(SPECIFY):***

58. **FOR ANY NEUROLOGIC EVENT INDICATED ABOVE, CHECK ALL THAT APPLY BELOW AND PROVIDE DETAILS IN THE COMMENTS AREA IN BOX 59.**

- ☐ DEPRESSED / ALTERED LEVEL OF CONSCIOUSNESS / LETHARGY / PERSONALITY CHANGE LASTING ≥ 24HRS
- ☐ FOCAL OR MULTIFOCAL NEUROLOGIC SIGN(S)
- ☐ FEVER (≥38.0°C)
- ☐ CSF ABNORMALITY
- ☐ EEG ABNORMALITY
- ☐ EMG ABNORMALITY
- ☐ NEUROIMAGING ABNORMALITY
- ☐ BRAIN / SPINAL CORD HISTOPATHOLOGIC ABNORMALITY

59. **ADDITIONAL DETAILS** (ATTACH FURTHER COMMENTS ON A SEPARATE SHEET AND REFERENCE THIS BOX NUMBER)

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V.4. OTHER DEFINED EVENTS OF INTEREST (ASTERISK (*) APPEARING NEXT TO A TERM INDICATES SPECIFIC EVENT THAT SHOULD BE DIAGNOSED BY A PHYSICIAN)

60. **ONSET**	(MINUTES)	(HOURS)	(DAYS)	FROM IMMUNIZATION TO ONSET OF 1ST SYMPTOM OR SIGN	☐ UNRESOLVED
61. **DURATION**	(MINUTES)	(HOURS)	(DAYS)	FROM ONSET OF 1ST SYMPTOM / SIGN TO RESOLUTION OF ALL SYMPTOMS / SIGNS	

62. ☐ **HYPOTONIC-HYPORESPONSIVE EPISODE** (AGE <2 YEARS)

☐ LIMPNESS ☐ PALLOR / CYANOSIS ☐ ↓RESPONSIVENESS / UNRESPONSIVENESS

63. ☐ **PERSISTENT CRYING** (CRYING WHICH IS CONTINUOUS AND UNALTERED FOR ≥ 3HRS)

64. ☐ **RASH** (FOR LOCAL REACTION RASH AT INJECTION SITE PLEASE DOCUMENT IN BOX 39. FOR ALLERGIC REACTION RASH PLEASE DOCUMENT USE BOX 43 SKIN / MUCOSAL WITH ADDITIONAL DETAILS IN BOX 48)

◯ GENERALIZED ◯ LOCALIZED AT NON-INJECTION SITE

65. ☐ **INTUSSUSCEPTION***

66. ☐ **ARTHRITIS** (CHECK ALL THAT APPLY)

☐ JOINT REDNESS ☐ JOINT WARM TO TOUCH ☐ JOINT SWELLING ☐ INFLAMMATORY CHANGES IN SYNOVIAL FLUID

67. ☐ **PAROTITIS** (PAROTID GLAND SWELLING WITH PAIN AND / OR TENDERNESS)

68. ☐ **THROMBOCYTOPENIA***

☐ CLINICAL EVIDENCE OF BLEEDING ☐ PLATELET COUNT < 150 X 10^9/L

69. ☐ **OCULO-RESPIRATORY SYNDROME (ORS)** (NOTE: THIS IS DIFFERENT FROM ALLERGIC/RESPIRATORY SYMPTOMS)

☐ BILATERAL RED EYES ☐ COUGH ☐ WHEEZE ☐ SORE THROAT ☐ DIFFICULTY SWALLOWING

☐ DIFFICULTY BREATHING ☐ CHEST TIGHTNESS ☐ HOARSENESS ☐ FACIAL SWELLING

70. ☐ **FEVER ≥ 38.0°C** (NOTE: REPORT ONLY IF FEVER OCCURS IN CONJUNCTION WITH A REPORTABLE EVENT. FOR FEVER IN A NEUROLOGICAL EVENT, USE SECTION V.3.)

71. ☐ **OTHER SERIOUS OR UNEXPECTED EVENT(S) NOT LISTED IN THE FORM** (SPECIFY AND PROVIDE DETAILS IN COMMENTS BOX 72)

72. **ADDITIONAL DETAILS** (ATTACH FURTHER COMMENTS ON A SEPARATE SHEET AND REFERENCE THIS BOX NUMBER)

V.5. IMPACT OF AEFI, OUTCOME, AND LEVEL OF CARE OBTAINED

73. **HIGHEST IMPACT OF AEFI** (CHOOSE ONE OF THE FOLLOWING)

◯ DID NOT INTERFERE WITH DAILY ACTIVITIES

◯ INTERFERED WITH BUT DID NOT PREVENT DAILY ACTIVITIES

◯ PREVENTED DAILY ACTIVITIES

74. **OUTCOME AT TIME OF REPORT**

◯ DEATH, (SPECIFY DATE):

(YYYY - MM - DD)

◯ FULLY RECOVERED ◯ NOT YET RECOVERED

◯ PERMANENT DISABILITY / INCAPACITY ◯ UNKNOWN

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75. **HIGHEST LEVEL OF CARE REQUIRED** (CHOOSE ONE OF THE FOLLOWING)

◯ EMERGENCY VISIT ◯ NON-URGENT VISIT ◯ NONE ◯ UNKNOWN

◯ TELEPHONE ADVICE FROM A HEALTH PROFESSIONAL

◯ REQUIRED HOSPITALIZATION FOR:	(DAYS)	OR	◯ RESULTED IN PROLONGATION OF EXISTING HOSPITALIZATION BY:	(DAYS)

76. **DATE OF HOSPITAL ADMISSION** (YYYY - MM - DD)	77. **DATE OF HOSPITAL DISCHARGE** (YYYY - MM - DD)

78. **TREATMENT RECEIVED** ◯ NO ◯ UNKNOWN ◯ YES (IF YES, PROVIDE DETAILS OF ALL TREATMENTS INCLUDING SELF-TREATMENT IN BOX 79)

79. **ADDITIONAL DETAILS** (ATTACH FURTHER COMMENTS ON A SEPARATE SHEET AND REFERENCE THIS BOX NUMBER)

V.6. PUBLIC HEALTH RECOMMENDATIONS (MUST BE COMPLETED BY A MEDICAL OFFICER OF HEALTH)

☐ NO CHANGE TO IMMUNIZATION SCHEDULE
☐ DETERMINE PROTECTIVE ANTIBODY LEVEL
☐ NO FURTHER IMMUNIZATIONS WITH (SPECIFY IN BOX 80)
☐ OTHER (SPECIFY IN BOX 80)
☐ EXPERT REFERRAL (SPECIFY IN BOX 70)
☐ CONTROLLED SETTING FOR NEXT IMMUNIZATION
☐ ACTIVE FOLLOW UP FOR AEFI RECURRENCE AFTER NEXT VACCINE
☐ NO RECOMMENDATIONS

80. **COMMENTS** (ATTACH FURTHER COMMENTS ON A SEPARATE SHEET AND REFERENCE THIS BOX NUMBER)

81. **LAST NAME**	82. **FIRST NAME**	83. **PHONE** (### - ### - ####)	**EXT. #** (####)

84. **DATE** (YYYY - MM - DD)	85. **SIGNATURE**

ASTERISK (*) APPEARING NEXT TO A TERM INDICATES SPECIFIC EVENT THAT SHOULD BE DIAGNOSED BY A PHYSICIAN.

PLEASE SUBMIT A COPY OF ALL AEFI REPORTS BY SECURED FAX OR COURIER TO THE MEDICAL OFFICER OF HEALTH (MOH) IN YOUR REGIONAL HEALTH AUTHORITY (RHA). PLEASE CHECK OUR WEBSITE FOR UP TO DATE CONTACT INFORMATION:

http://www.gov.mb.ca/health/publichealth/contactlist.html

AFTER HOURS EMERGENCY PHONE FOR PUBLIC HEALTH ISSUES: (204) 788-8666