

UNIQUE EPISODE NUMBER

IMPACT LIN

# 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 <input type="radio"/> FEMALE <input type="radio"/> MALE <input type="radio"/> 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 <input type="radio"/> PHYSICIAN OFFICE <input type="radio"/> PUBLIC HEALTH <input type="radio"/> HOSPITAL <input type="radio"/> PHARMACY <input type="radio"/> 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 <input type="radio"/> MD <input type="radio"/> RN <input type="radio"/> IMPACT <input type="radio"/> OTHER (SPECIFY):		


## III. SOURCE OF INFORMATION

<input type="radio"/> SAME AS REPORTER <input type="radio"/> CLIENT <input type="radio"/> 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 (## : ##)  <input type="radio"/> AM <input type="radio"/> 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? <input type="radio"/> NO <input type="radio"/> NO PRIOR DOSES <input type="radio"/> UNKNOWN <input type="radio"/> 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? <input type="radio"/> NO <input type="radio"/> UNKNOWN <input type="radio"/> YES (IF YES, CHOOSE ALL THAT APPLY AND PROVIDE DETAILS IN BOX 33)								
<input type="checkbox"/> GIVEN OUTSIDE THE RECOMMENDED AGE LIMITS <input type="checkbox"/> DOSE EXCEEDED THAT RECOMMENDED FOR AGE <input type="checkbox"/> INCORRECT ROUTE <input type="checkbox"/> WRONG VACCINE GIVEN <input type="checkbox"/> PRODUCT EXPIRED <input type="checkbox"/> 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) <input type="checkbox"/> CONCOMITANT MEDICATION(S) <input type="checkbox"/> KNOWN MEDICAL CONDITIONS / ALLERGIES <input type="checkbox"/> 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

<b>V.1. LOCAL REACTION AT OR NEAR VACCINATION SITE</b>					
36. <b>ONSET</b>	(MINUTES)	(HOURS)	(DAYS)	FROM IMMUNIZATION TO ONSET OF 1ST SYMPTOM OR SIGN	<input type="checkbox"/> UNRESOLVED
37. <b>DURATION</b>	(MINUTES)	(HOURS)	(DAYS)	FROM ONSET OF 1ST SYMPTOM / SIGN TO RESOLUTION OF ALL SYMPTOMS / SIGNS	
<input type="checkbox"/> INFECTED ABSCESS <input type="checkbox"/> STERILE ABSCESS <input type="checkbox"/> CELLULITIS <input type="checkbox"/> NODULE <input type="checkbox"/> REACTION CROSSES JOINT <input type="checkbox"/> LYMPHADENITIS <input type="checkbox"/> OTHER, (SPECIFY):					
38. <b>ADDITIONAL DETAILS</b> (ATTACH FURTHER COMMENTS ON A SEPARATE SHEET AND REFERENCE THIS BOX NUMBER)					
39. <b>FOR ANY INJECTION SITE REACTION INDICATED ABOVE, CHECK ALL THAT APPLY BELOW AND PROVIDE DETAILS IN THE COMMENTS AREA IN BOX 40.</b>					
<input type="checkbox"/> SWELLING <input type="checkbox"/> PAIN <input type="checkbox"/> TENDERNESS <input type="checkbox"/> ERYTHEMA <input type="checkbox"/> WARMTH <input type="checkbox"/> INDURATION <input type="checkbox"/> RASH					
<input type="checkbox"/> LARGEST DIAMETER OF VACCINATION SITE REACTION (SPECIFY): →		(CM)		<input type="checkbox"/> SITE(S) OF REACTION (SPECIFY): →	(e.g., LA, RA)
<input type="checkbox"/> PALPABLE FLUCTUANCE <input type="checkbox"/> FLUID COLLECTION SHOWN BY IMAGING TECHNIQUE (E.G., MRI, CT, ULTRASOUND) <input type="checkbox"/> SPONTANEOUS/SURGICAL DRAINAGE <input type="checkbox"/> MICROBIAL RESULTS <input type="checkbox"/> LYMPHANGITIC STREAKING <input type="checkbox"/> REGIONAL LYMPHADENOPATHY					
40. <b>ADDITIONAL DETAILS</b> (ATTACH FURTHER COMMENTS ON A SEPARATE SHEET AND REFERENCE THIS BOX NUMBER)					
<b>V.2. ANAPHYLAXIS OR OTHER ALLERGIC EVENTS</b>					
41. <b>ONSET</b>	(MINUTES)	(HOURS)	(DAYS)	FROM IMMUNIZATION TO ONSET OF 1ST SYMPTOM OR SIGN	<input type="checkbox"/> UNRESOLVED
42. <b>DURATION</b>	(MINUTES)	(HOURS)	(DAYS)	FROM ONSET OF 1ST SYMPTOM / SIGN TO RESOLUTION OF ALL SYMPTOMS / SIGNS	
43. <b>CHOOSE ONE OF THE FOLLOWING:</b> <input type="radio"/> ANAPHYLAXIS <input type="radio"/> OTHER ALLERGIC EVENTS					
44. <input type="checkbox"/> <b>SKIN / MUCOSAL</b>					
<input type="radio"/> GENERALIZED		<input type="checkbox"/> AT INJECTION SITE <input type="checkbox"/> NON-INJECTION SITE <input type="checkbox"/> URTICARIA <input type="checkbox"/> ERYTHEMA <input type="checkbox"/> PRURITUS <input type="checkbox"/> PRICKLE SENSATION			
<input type="radio"/> LOCALIZED		<input type="checkbox"/> AT INJECTION SITE <input type="checkbox"/> NON-INJECTION SITE <input type="checkbox"/> URTICARIA <input type="checkbox"/> ERYTHEMA <input type="checkbox"/> PRURITUS <input type="checkbox"/> PRICKLE SENSATION			
EYES		<input type="checkbox"/> RED <input type="checkbox"/> ITCHY			
ANGIOEDEMA		<input type="checkbox"/> TONGUE <input type="checkbox"/> THROAT <input type="checkbox"/> UVULA <input type="checkbox"/> LARYNX <input type="checkbox"/> LIP <input type="checkbox"/> EYELIDS <input type="checkbox"/> LIMBS <input type="checkbox"/> OTHER, (SPECIFY):			

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45. <input type="checkbox"/> <b>CARDIO-VASCULAR</b>	<input type="checkbox"/> MEASURED HYPOTENSION	<input type="checkbox"/> ↓ CENTRAL PULSE VOLUME	<input type="checkbox"/> CAPILLARY REFILL TIME >3 SEC	
	<input type="checkbox"/> TACHYCARDIA	<input type="checkbox"/> ↓ OR LOSS OF CONSCIOUSNESS		
46. <input type="checkbox"/> <b>RESPIRATORY</b>	<input type="checkbox"/> SNEEZING	<input type="checkbox"/> RHINORRHEA	<input type="checkbox"/> HOARSE VOICE	<input type="checkbox"/> STRIDOR
	<input type="checkbox"/> DRY COUGH	<input type="checkbox"/> TACHYPNEA	<input type="checkbox"/> WHEEZING	<input type="checkbox"/> GRUNTING
	<input type="checkbox"/> CYANOSIS	<input type="checkbox"/> INDRAWING / RETRACTIONS		
	<input type="checkbox"/> SENSATION OF THROAT CLOSURE			
47. <input type="checkbox"/> <b>GASTROINTESTINAL</b>	<input type="checkbox"/> DIARRHEA	<input type="checkbox"/> ABDOMINAL PAIN	<input type="checkbox"/> NAUSEA	<input type="checkbox"/> 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. <b>ONSET</b>	(MINUTES)	(HOURS)	(DAYS)	FROM IMMUNIZATION TO ONSET OF 1ST SYMPTOM OR SIGN	<input type="checkbox"/> UNRESOLVED
50. <b>DURATION</b>	(MINUTES)	(HOURS)	(DAYS)	FROM ONSET OF 1ST SYMPTOM / SIGN TO RESOLUTION OF ALL SYMPTOMS / SIGNS	
51. <input type="checkbox"/> <b>SEIZURE(S)</b> (CHECK ALL THAT APPLY)	<input type="checkbox"/> WITNESSED BY HEALTHCARE PROFESSIONAL <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNKNOWN				
	<input type="checkbox"/> SUDDEN LOSS OF CONSCIOUSNESS <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNKNOWN				
	<input type="radio"/> FOCAL				
	<input type="radio"/> GENERALIZED				
	<input type="radio"/> TONIC <input type="radio"/> CLONIC <input type="radio"/> TONIC-CLONIC <input type="radio"/> ATONIC <input type="radio"/> ABSENCE <input type="radio"/> MYOCLONIC				
<input type="checkbox"/> PREVIOUS HISTORY OF SEIZURES					
<input type="radio"/> FEBRILE <input type="radio"/> AFEBRILE <input type="radio"/> UNKNOWN TYPE					
52. <input type="checkbox"/> <b>MENINGITIS*</b>	53. <input type="checkbox"/> <b>ENCEPHALOPATHY / ENCEPHALITIS*</b>		54. <input type="checkbox"/> <b>GUILLAIN-BARRE SYNDROME (GBS)*</b>		
55. <input type="checkbox"/> <b>BELL'S PALSY*</b>	56. <input type="checkbox"/> <b>OTHER PARALYSIS*</b>				
57. <input type="checkbox"/> <b>OTHER NEUROLOGIC DIAGNOSIS* (SPECIFY):</b>					

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

<input type="checkbox"/> DEPRESSED / ALTERED LEVEL OF CONSCIOUSNESS / LETHARGY / PERSONALITY CHANGE LASTING ≥ 24HRS	<input type="checkbox"/> FOCAL OR MULTIFOCAL NEUROLOGIC SIGN(S)
<input type="checkbox"/> FEVER (≥38.0°C)	<input type="checkbox"/> CSF ABNORMALITY <input type="checkbox"/> EEG ABNORMALITY <input type="checkbox"/> EMG ABNORMALITY
<input type="checkbox"/> NEUROIMAGING ABNORMALITY	<input type="checkbox"/> BRAIN / SPINAL CORD HISTOPATHOLOGIC ABNORMALITY

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

**Manitoba**  
Health, Seniors and Active Living

60. <b>ONSET</b>	(MINUTES)	(HOURS)	(DAYS)	FROM IMMUNIZATION TO ONSET OF 1ST SYMPTOM OR SIGN	<input type="checkbox"/> UNRESOLVED
61. <b>DURATION</b>	(MINUTES)	(HOURS)	(DAYS)	FROM ONSET OF 1ST SYMPTOM / SIGN TO RESOLUTION OF ALL SYMPTOMS / SIGNS	
62. <input type="checkbox"/> <b>HYPOTONIC-HYPORESPONSIVE EPISODE</b> (AGE <2 YEARS)					
<input type="checkbox"/> LIMPNESS <input type="checkbox"/> PALLOR / CYANOSIS <input type="checkbox"/> IRESPONSIVENESS / UNRESPONSIVENESS					
63. <input type="checkbox"/> <b>PERSISTENT CRYING</b> (CRYING WHICH IS CONTINUOUS AND UNALTERED FOR ≥ 3HRS)					
64. <input type="checkbox"/> <b>RASH</b> (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)					
<input type="radio"/> GENERALIZED <input type="radio"/> LOCALIZED AT NON-INJECTION SITE					
65. <input type="checkbox"/> <b>INTUSSUSCEPTION*</b>					
66. <input type="checkbox"/> <b>ARTHRITIS</b> (CHECK ALL THAT APPLY)					
<input type="checkbox"/> JOINT REDNESS <input type="checkbox"/> JOINT WARM TO TOUCH <input type="checkbox"/> JOINT SWELLING <input type="checkbox"/> INFLAMMATORY CHANGES IN SYNOVIAL FLUID					
67. <input type="checkbox"/> <b>PAROTITIS</b> (PAROTID GLAND SWELLING WITH PAIN AND / OR TENDERNESS)					
68. <input type="checkbox"/> <b>THROMBOCYTOPENIA*</b>					
<input type="checkbox"/> CLINICAL EVIDENCE OF BLEEDING <input type="checkbox"/> PLATELET COUNT < 150 X 10 <sup>9</sup> /L					
69. <input type="checkbox"/> <b>OCULO-RESPIRATORY SYNDROME (ORS)</b> (NOTE: THIS IS DIFFERENT FROM ALLERGIC/RESPIRATORY SYMPTOMS)					
<input type="checkbox"/> BILATERAL RED EYES <input type="checkbox"/> COUGH <input type="checkbox"/> WHEEZE <input type="checkbox"/> SORE THROAT <input type="checkbox"/> DIFFICULTY SWALLOWING					
<input type="checkbox"/> DIFFICULTY BREATHING <input type="checkbox"/> CHEST TIGHTNESS <input type="checkbox"/> HOARSENESS <input type="checkbox"/> FACIAL SWELLING					
70. <input type="checkbox"/> <b>FEVER ≥ 38.0°C</b> (NOTE: REPORT ONLY IF FEVER OCCURS IN CONJUNCTION WITH A REPORTABLE EVENT. FOR FEVER IN A NEUROLOGICAL EVENT, USE SECTION V.3.)					
71. <input type="checkbox"/> <b>OTHER SERIOUS OR UNEXPECTED EVENT(S) NOT LISTED IN THE FORM</b>					(SPECIFY AND PROVIDE DETAILS IN COMMENTS BOX 72)
72. <b>ADDITIONAL DETAILS</b> (ATTACH FURTHER COMMENTS ON A SEPARATE SHEET AND REFERENCE THIS BOX NUMBER)					

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

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74. **OUTCOME AT TIME OF REPORT**

<input type="radio"/> DEATH, (SPECIFY DATE):  (YYYY - MM - DD)	<input type="radio"/> FULLY RECOVERED	<input type="radio"/> NOT YET RECOVERED
	<input type="radio"/> PERMANENT DISABILITY / INCAPACITY	<input type="radio"/> UNKNOWN

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75. <b>HIGHEST LEVEL OF CARE REQUIRED</b> (CHOOSE ONE OF THE FOLLOWING)			
<input type="radio"/> EMERGENCY VISIT		<input type="radio"/> NON-URGENT VISIT	
<input type="radio"/> TELEPHONE ADVICE FROM A HEALTH PROFESSIONAL		<input type="radio"/> NONE	
<input type="radio"/> REQUIRED HOSPITALIZATION FOR:		<input type="radio"/> RESULTED IN PROLONGATION OF EXISTING HOSPITALIZATION BY:	
(DAYS)		(DAYS)	
76. <b>DATE OF HOSPITAL ADMISSION</b>		77. <b>DATE OF HOSPITAL DISCHARGE</b>	
(YYYY - MM - DD)		(YYYY - MM - DD)	
78. <b>TREATMENT RECEIVED</b> <input type="radio"/> NO <input type="radio"/> UNKNOWN <input type="radio"/> YES		(IF YES, PROVIDE DETAILS OF ALL TREATMENTS INCLUDING SELF-TREATMENT IN BOX 79)	
79. <b>ADDITIONAL DETAILS</b> (ATTACH FURTHER COMMENTS ON A SEPARATE SHEET AND REFERENCE THIS BOX NUMBER)			
<b>V.6. PUBLIC HEALTH RECOMMENDATIONS (MUST BE COMPLETED BY A MEDICAL OFFICER OF HEALTH)</b>			
<input type="checkbox"/> NO CHANGE TO IMMUNIZATION SCHEDULE		<input type="checkbox"/> EXPERT REFERRAL (SPECIFY IN BOX 70)	
<input type="checkbox"/> DETERMINE PROTECTIVE ANTIBODY LEVEL		<input type="checkbox"/> CONTROLLED SETTING FOR NEXT IMMUNIZATION	
<input type="checkbox"/> NO FURTHER IMMUNIZATIONS WITH (SPECIFY IN BOX 80)		<input type="checkbox"/> ACTIVE FOLLOW UP FOR AEFI RECURRENCE AFTER NEXT VACCINE	
<input type="checkbox"/> OTHER (SPECIFY IN BOX 80)		<input type="checkbox"/> NO RECOMMENDATIONS	
80. <b>COMMENTS</b> (ATTACH FURTHER COMMENTS ON A SEPARATE SHEET AND REFERENCE THIS BOX NUMBER)			
81. <b>LAST NAME</b>	82. <b>FIRST NAME</b>	83. <b>PHONE</b>	<b>EXT. #</b>
		(### - ### - #####)	(####)
84. <b>DATE</b>	85. <b>SIGNATURE</b>		
(YYYY - MM - DD)			

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