Report of Adverse Event Following Immunization (AEFI)

Public Health Ontario | Santé publique Ontario

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 #:

Address:	City:	Postal Code:

Reported to public health by:	Relationship with case:	Date of report (yyyy/mm/dd):

Form completed by:	Contact information (if different from above):

2 - IMMUNIZATION INFORMATION

Date (yyyy/mm/dd)	Time (24hr - HH:MM)	Agent and Manufacturer	Lot #	Exp. date (yyyy/mm/dd)	Dose #	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	Specify minutes or hours or days: Time to onset of event	Duration of event
☐ 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 of event	Duration of event
☐ Fever greater than 38.0ºC (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	Specify minutes or hours or days: Time to onset of event	Duration of event
☐ Event managed as anaphylaxis		
☐ Oculorespiratory syndrome (ORS)		
☐ Allergic reaction - skin (E.g. hives)		

Neurologic Events	Time to onset of event	Duration of event
☐ 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 of event	Duration of event
☐ Thrombocytopenia*		
☐ Arthritis / arthralgia*		
☐ Intussusception*		
☐ Syncope (fainting) with injury		
☐ Other severe / unusual events		

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)

Describe:

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 that 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:

Date (yyyy/mm/dd)

Signature:

The personal health information provided on this form is collected under the authority of the *Health Protection and Promotion Act* and O. Reg 569. 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.

Ontario
Agency for Health Protection and Promotion
Agence de protection et de promotion de la santé