

# Adverse Event Following Immunisation Reporting Form January 2025

Office Use Only  
Date Report Received  
QH ID no.  
TGA ID no.

Vaccinated person details	Vaccination provider details
<p>Surname <input type="text"/> First name <input type="text"/></p> <p>Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other, please specify <input type="text"/></p> <p>Date of Birth <input type="text"/></p> <p>Street Address <input type="text"/></p> <p>Suburb <input type="text"/> State <input type="text"/> Postcode <input type="text"/></p> <p>Name of parent/guardian/substitute decision maker (if relevant) <input type="text"/></p> <p>Phone Home <input type="text"/> Mobile <input type="text"/></p> <p>Email <input type="text"/></p> <p><b>Indigenous status</b> Is the person of Aboriginal or Torres Strait Islander origin?  <input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander  <input type="checkbox"/> Aboriginal and Torres Strait Islander  <input type="checkbox"/> Not Aboriginal or Torres Strait Islander <input type="checkbox"/> Not Stated/Unknown</p> <p>Important medical history (e.g. requires regular medical follow up)  <input type="text"/></p> <p>Allergies <input type="text"/></p> <p>Was the person ill at the time of vaccination?  <input type="checkbox"/> No <input type="checkbox"/> Yes - please specify <input type="text"/></p> <p>Has the vaccinated person had previous reactions to vaccinations?  <input type="checkbox"/> No <input type="checkbox"/> Yes - please specify <input type="text"/>  <input type="checkbox"/> Unknown</p>	<p>Surname <input type="text"/> First name <input type="text"/></p> <p>Practice/clinic/provider name: <input type="text"/></p> <p>Street Address <input type="text"/></p> <p>Suburb <input type="text"/> State <input type="text"/> Postcode <input type="text"/></p> <p>Phone Office <input type="text"/> Mobile <input type="text"/></p> <p>Email <input type="text"/></p> <p>Fax <input type="text"/></p> <p><b>Profession</b>  <input type="checkbox"/> Medical practitioner <input type="checkbox"/> Registered Nurse <input type="checkbox"/> Pharmacist  <input type="checkbox"/> Other, please specify <input type="text"/></p> <p><b>Clinical setting</b>  <input type="checkbox"/> GP practice <input type="checkbox"/> Aged care facility <input type="checkbox"/> School Immunisation Program  <input type="checkbox"/> Hospital <input type="checkbox"/> Community Clinic <input type="checkbox"/> Pharmacy  <input type="checkbox"/> Other, please specify <input type="text"/></p> <p><b>Address of service where vaccine was administered</b>  <input type="checkbox"/> As for vaccination provider          (above) or          Name of practice/clinic/provider <input type="text"/>          Street Address <input type="text"/>          Suburb <input type="text"/> State <input type="text"/> Postcode <input type="text"/>          Phone Office <input type="text"/> Mobile <input type="text"/>          Email <input type="text"/></p>
<b>Reporter details (if different from vaccinated person details or vaccination provider details)</b>	
<p><input type="checkbox"/> As per vaccination provider details (above) OR <input type="checkbox"/> As per vaccinated person's details (above) OR</p> <p>Surname <input type="text"/> First name <input type="text"/> Practice Name (if relevant) <input type="text"/></p> <p>Street Address <input type="text"/> Suburb <input type="text"/> State <input type="text"/> Postcode <input type="text"/></p> <p>Phone landline (incl. area code) <input type="text"/> Phone mobile <input type="text"/></p> <p>Email <input type="text"/> Date of report <input type="text"/></p> <p><b>Reporter type</b>  <input type="checkbox"/> Medical practitioner <input type="checkbox"/> Registered nurse <input type="checkbox"/> Pharmacist <input type="checkbox"/> Vaccinated person <input type="checkbox"/> Parent/guardian/substitute decision maker  <input type="checkbox"/> Public Health Unit <input type="checkbox"/> Other, please specify <input type="text"/></p> <p><b>If you require further information following an adverse event, please contact your local Public Health Unit.</b></p>	
<b>Consent statement</b>	
<p>I, the reporter, agree to be contacted for further follow up regarding this adverse event if necessary. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Name <input type="text"/> Date <input type="text"/></p> <p><b>Please advise the person/parent/guardian/substitute decision maker that contact details will be used to follow up if information is needed.</b></p>	

Vaccine details						
Vaccine (brand name)	Dose number (e.g. 1 or 2)	Batch Number	Date given	Time given	Route of administration	Injection site
					<input type="checkbox"/> O <input type="checkbox"/> IM <input type="checkbox"/> SC <input type="checkbox"/> ID <input type="checkbox"/> IN <input type="checkbox"/> U	<input type="checkbox"/> RA <input type="checkbox"/> LA <input type="checkbox"/> U <input type="checkbox"/> RL <input type="checkbox"/> LL <input type="checkbox"/> NA
					<input type="checkbox"/> O <input type="checkbox"/> IM <input type="checkbox"/> SC <input type="checkbox"/> ID <input type="checkbox"/> IN <input type="checkbox"/> U	<input type="checkbox"/> RA <input type="checkbox"/> LA <input type="checkbox"/> U <input type="checkbox"/> RL <input type="checkbox"/> LL <input type="checkbox"/> NA
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					<input type="checkbox"/> O <input type="checkbox"/> IM <input type="checkbox"/> SC <input type="checkbox"/> ID <input type="checkbox"/> IN <input type="checkbox"/> U	<input type="checkbox"/> RA <input type="checkbox"/> LA <input type="checkbox"/> U <input type="checkbox"/> RL <input type="checkbox"/> LL <input type="checkbox"/> NA
					<input type="checkbox"/> O <input type="checkbox"/> IM <input type="checkbox"/> SC <input type="checkbox"/> ID <input type="checkbox"/> IN <input type="checkbox"/> U	<input type="checkbox"/> RA <input type="checkbox"/> LA <input type="checkbox"/> U <input type="checkbox"/> RL <input type="checkbox"/> LL <input type="checkbox"/> NA
Adverse event details: (Please tick a box) <input type="checkbox"/> Adverse Event <input type="checkbox"/> Vaccine Administration Error						
Onset of event:   Date <input type="text"/> Time <input type="text"/>						
Description of events, including timeline of occurrences (please provide separate page if needed):						
<div></div>						
All adverse events						
Symptom(s)	Onset date	Onset time	Resolved date (leave blank if ongoing)	Resolved time		
<input type="checkbox"/> Injection site reation*						
<input type="checkbox"/> Generalised itch*						
<input type="checkbox"/> Fatigue*						
<input type="checkbox"/> Muscle and joint pain*						
<input type="checkbox"/> Fever*						
<input type="checkbox"/> Rash*						
<input type="checkbox"/> Enlarged lymph nodes*						
<input type="checkbox"/> Anaphylaxis or anaphylactic shock*						
<input type="checkbox"/> Demyelination events*						
<input type="checkbox"/> Neurological events*						
<input type="checkbox"/> Facial tingling*						
<input type="checkbox"/> Facial drooping*						
<input type="checkbox"/> Death*#						
<input type="checkbox"/> Thrombosis*						
<input type="checkbox"/> Others, specify*						
Additional description of an adverse reaction/s:						
* All adverse event reports are referred to a Public Health Unit for further assessment and review.						
# All Fatal AEFI must be reported to the Queensland Coroner. This does not replace the requirement of a death to be reported to Queensand Health using the AEFI reporting process under the <i>Public Health Act 2005</i> .						

**Management of event:** (tick as many as apply)☐ Nurse assessment   ☐ Medical assessment   ☐ GP assessment   ☐ Hospital emergency department   ☐ Pharmacist☐ Hospital admission

Date of admission

Date of discharge

☐ Self☐ Unknown☐ None☐ Other, please specify

Please specify the treatment/care provided (e.g. antibiotics, adrenaline, advice, counselling, etc.):

**Office use only - Public Health Unit**Is follow-up of the person required? ☐ No   ☐ Yes —Timeframe for follow up   ☐ Same day   ☐ Next working day   ☐ Next 60 days

Details:

Signature

SIGN HERE

Date

Once you have completed this form, you can either:

1. Click 'Save As' button to save the form for your records. Attach to an email for sending to [CDIS-NOCS-Support@health.qld.gov.au](mailto:CDIS-NOCS-Support@health.qld.gov.au)  
OR
2. Click the 'Print' button, scan the form and then attach it to an email for sending to [CDIS-NOCS-Support@health.qld.gov.au](mailto:CDIS-NOCS-Support@health.qld.gov.au)  
OR
3. Open the form in Acrobat desktop and click 'Email' button to send to [CDIS-NOCS-Support@health.qld.gov.au](mailto:CDIS-NOCS-Support@health.qld.gov.au)  
(Note: This requires the latest version of Adobe Acrobat and does not save the form for your records)  
OR
4. Fax the form to (07) 3328 9434

**Save As****Print****Email****Privacy statement**

The *Information Privacy Act 2009* sets out ways in which a health agency can collect personal information for the purpose of reporting Adverse Events Following Immunisation (AEFI). The *Public Health Act 2005* requires the AEFI to be reported to Queensland Health for inclusion on the Notifiable Conditions Register (NoCS). If further follow up is required following an adverse event, the information stored on the Notifiable Conditions Register will be used. AEFI reports and collects details such as the vaccinated person's name, contact information and relevant health information. Details pertaining to the adverse event, important medical history relevant for follow up following the adverse event, details of the provider who administered the vaccine, reporter details and vaccination details are requested and recorded for each AEFI report. Authorised Queensland Health staff may access the information for the purpose of clinical follow up and monitoring. Personal information will not be accessed by or given to any other person or organisation without permission unless permitted or required by law. For information about how Queensland Health protects personal information, or to learn about the right to access your own personal information, please see our website at [www.health.qld.gov.au/system-governance/records-privacy](http://www.health.qld.gov.au/system-governance/records-privacy)

All reports are provided to the Therapeutic Goods Administration (TGA) to be entered into the TGA's Australian Adverse Drugs Reactions System (the ADRS). Information about how the TGA uses adverse event information that is reported is available at [www.tga.gov.au/safety/problem.htm](http://www.tga.gov.au/safety/problem.htm)

**Reset Partial**

Clicking the 'Reset Partial' button will maintain the data entered in the Vaccination Provider Details and Reporter Details sections. However, all the other information in the form will be removed.

**Reset All**

Clicking the 'Reset All' button will remove all the information from this form.

END OF FORM