MINISTRY OF HEALTH & WELLNESS

ESAVI reporting ID number:

MINISTRY OF HEALTH AND WELLNESS

REPORTING FORM FOR EVENTS SUPPOSEDLY ATTRIBUTED TO VACCINATION OR IMMUNIZATION (ESAVI)

***Patient Name**:* _____	***Reporter's Name**:* _____
***Patient's full Address**:* _____	Institution: _____
_____	Post & Department: _____
Telephone: _____	Address: _____
Sex: ☐ M ■ F Currently pregnant: ☐ Yes ☐ No	_____
***Date of birth (DD/MM/YYYY)**:* _ _ _ _ _ _ _ _	Telephone & E-mail: _____
OR Age at onset: _____Years _____Months _____Days	Date patient notified event to health system *(DD/MM/YYYY)*: _ _ _ _ _ _ _ _
	Today's date *(DD/MM/YYYY)*: _ _ _ _ _ _ _ _

Health Facility (place or vaccination centre) name & address:

Vaccine						***Diluent (if applicable)***			
Name of vaccine	***Date of vaccination***	***Time of vaccination***	Dose (1st, 2nd, etc.)	***Batch /Lot number***	Expiry date	Name of diluent	***Batch /Lot number***	Expiry date	Date and time of reconstitution

Adverse event(s):

☐ Local reaction ☐ *> 3 days* ☐ *beyond nearest joint*
☐ *pain* ☐ *redness* ☐ *swelling*
☐ Seizures
☐ *febrile* ☐ *afebrile*
☐ Headache
☐ Fever ≥ 38°C
☐ Abscess
☐ Myalgia
☐ Sepsis
☐ Encephalopathy
☐ Thrombocytopenia
☐ Anaphylaxis
Other *(specify)*
☐ .....
☐ .....
☐ .....

Date ESAVI started *(DD/MM/YYYY)*: _ _ _ _ _ _ _ **Time** _ _:_ _
Describe ESAVI (Signs & Symptoms) and Treatment *(if any)*:

Serious: ☐ ***Yes*** ☐ ***No;*** → If Yes ☐ Death ☐ Life threatening ☐ Persistent or significant disability ☐ Hospitalization ☐ Congenital anomaly
☐ Other important medical event (specify).....

Outcome: ☐ Recovering ☐ Recovered ☐ Recovered with sequelae ☐ Not Recovered ☐ Unknown

☐ Died If Died, date of death *(DD/MM/YYYY)*: _ _ _ _ _ _ _ _ Autopsy done: ☐ Yes ☐ No ☐ Unknown

Past medical history (including history of similar reaction or other allergies), concomitant medication and other relevant information (e.g. other cases). *Use additional sheets if needed:*

Parish level to complete:

Investigation needed: ☐ Yes ☐ No	If Yes, date investigation planned *(DD/MM/YYYY)*: _ _ _ _ _ _

Reviewed and signed off by MO(H): _____ *Date (DD/MM/YYYY)*: _ _ _ _ _ _
Name and Signature

National level to complete

Date report received at National level *(DD/MM/YYYY)*: _ _ _ _ _ _	ESAVI worldwide unique ID :
Comments:	

**** Compulsory field***