



# Report of Suspected Adverse Reaction to Vaccines

ADR Report No. \_\_\_\_\_

Date of notification: \_\_\_ / \_\_\_ / 2010      Person completing form: \_\_\_\_\_  
*Please PRINT name*

## Notifying Person

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Contact numbers: Work \_\_\_\_\_ Mobile \_\_\_\_\_

## Case Details

Given name: \_\_\_\_\_ Family name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Suburb: \_\_\_\_\_ Postcode \_\_\_\_\_  
 Contact numbers: Home \_\_\_\_\_ Mobile \_\_\_\_\_  
 Date of birth: \_\_\_ / \_\_\_ / \_\_\_\_\_ Sex:  Male  Female Weight: \_\_\_\_\_ kg

## Vaccine Provider (if different to notifying person)

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Contact numbers: Work \_\_\_\_\_ Mobile \_\_\_\_\_

## Vaccines given 14 days prior to adverse reaction

Brand name	Date given (dd/mm/yyyy)	Time given	Dose No. (eg DTP1)	Batch Number

## Prior Influenza Vaccines

Any prior **seasonal influenza vaccine**:  Yes  No  Unknown  
 If yes, provide year and dose(s) given:  
 2009  One  Two  Unknown  
 2008  One  Two  Unknown  
 2007  One  Two  Unknown  
 Prior Panvax (H1N1 2009 virus) vaccine:  Yes  No  Unknown

## Clinical History

*Tick if applicable*

Date of onset of symptoms: \_\_\_ / \_\_\_ / \_\_\_\_\_ Time of onset \_\_\_\_\_  
 Recorded fever Temp: \_\_\_\_\_ °C  Rigors (shakes/chills)  
 Fever (self-report)  Headache  
 Convulsions  Diarrhoea  
 Shortness of breath/difficulty breathing  Rash  
 Vomiting  Local reaction or swelling  
 Fatigue  Myalgia  
 Other, specify: \_\_\_\_\_  
 Sequelae:  No  Yes Description: \_\_\_\_\_

**Outcome:**Life threatening:  No  YesRequired a visit to a GP  No  Yes Visit date : \_\_\_ / \_\_\_ / \_\_\_Required a visit to ED  No  Yes Visit date : \_\_\_ / \_\_\_ / \_\_\_Hospitalised  No  Yes

If yes, Admission date : \_\_\_ / \_\_\_ / \_\_\_ Discharge date: \_\_\_ / \_\_\_ / \_\_\_

Hospital (s): \_\_\_\_\_

Ward admitted to: \_\_\_\_\_

If admitted to ICU  No  Yes ~ No. of days: \_\_\_\_\_If ventilated  No  Yes ~ No. of days: \_\_\_\_\_ Recovered Date: \_\_\_ / \_\_\_ / \_\_\_  Not yet recovered Fatal Date of death: \_\_\_ / \_\_\_ / \_\_\_  Unknown**Medical History***(Tick one or more)*History of previous febrile seizures  Yes  NoHistory of seizures (afebrile)  Yes  NoHistory of adverse event following immunisation  Yes  No

If yes, describe \_\_\_\_\_

Diabetes  Yes  NoChronic heart disease  Yes  NoChronic respiratory disease  Yes  NoChronic renal disease  Yes  NoChronic neurological disease  Yes  NoChronic blood disease  Yes  NoMetabolic disease  Yes  NoImpaired immunity (eg. cancer, HIV, immunosuppressant drugs)  Yes  No

Other medical conditions: \_\_\_\_\_

Please fax completed forms to Communicable Disease Control Directorate on (08) 9388 4877

or mail to CDCD Department of Health PO Box 8172, PERTH BUSINESS CENTRE WA 6849