health
Department:
Health
REPUBLIC OF SOUTH AFRICA

CASE REPORTING FORM (CRF) FOR ADVERSE EVENTS FOLLOWING IMMUNISATION (AEFI)

EPID Number: S O A - | | | | - | | | | - | | | | - | | | | | |

Country - Province - District - Year - Case no

All fields in this form are mandatory

**Compulsory field*

Received on (date)	*Level*	*Signature*
	District	
	Province	
	National EPI	
	National SAHPRA	

(For Office use only)

SECTION A: IDENTIFYING INFORMATION

*Patient name and surname:

_____

*Patient's residential address: _____

_____

_____

Caregiver's name and surname: _____

Telephone: _____

Please tick (√) the appropriate box

Gender: ☐ M ☐ F Term: ☐ Full term ☐ Premature

*Date of birth (DD/MM/YYYY): __ __/__ __/__ __ __ __

Age at onset: ☐☐ Years ☐☐ Months ☐☐☐ Days

*Reporter's name and surname:

_____

Designation/Position: _____

Institution: _____

Telephone: _____

*Mobile no: _____

*E-mail: _____

Date patient notified event to health system (DD/MM/YYYY):

__ __/__ __/__ __ __ __

Today's date (DD/MM/YYYY): __ __/__ __/__ __ __ __

SECTION B: VACCINE INFORMATION (Please attach a copy of the Road to Heath Booklet (RTHB))

Health facility (or vaccination center) name: _____

Vaccine/s administered *(Complete this section only for alleged vaccines /vaccines that were administered before the event)*								**Diluent** *(Where applicable)*		
*Vaccines given (Use trade names)	*Date of vaccination	*Time of vaccination	Dose number (e.g. 1st, 2nd, 3rd)	*Batch/ Lot number	Expiry date	*VVM Stage (If applies)	*Manufacturer	*Batch/ Lot number	Expiry date	Date and time of reconstitution

Patient name & surname: _____ EPID Number: _____

SECTION C: TRIGGER EVENTS

Date & time AEFI started: (DD/MM/YYYY) __ __/__ __/__ __ __ __ ☐☐ Hr ☐☐ Min

Adverse event (s): (Tick (✓) all boxes that apply)

Minor reactions	***Severe local reactions***	***Systemic reactions***
☐ Swelling <5cm	☐ Pain, redness and/or swelling of more than 3 days duration	☐ Hospitalization
☐ Redness	☐ Swelling >5cm	☐ Death
☐ Rash	☐ Swelling beyond nearest joint	☐ Anaphylaxis
☐ Excessive crying	☐ Lymphadenitis	☐ Fever ≥38°C
☐ Fever <38°C	☐ Abscess	☐ Encephalopathy
☐ Other (specify):	☐ Other (specify):	☐ Collapse / shock-like state
_____	_____	☐ Seizures ☐ Febrile ☐ Afebrile
_____	_____	☐ Intussusception
_____	_____	☐ Diarrhoea
		☐ Vomiting
		☐ Toxic shock syndrome
		☐ Thrombocytopenia
		☐ Sepsis
		☐ Other (specify): _____
		_____

Severe or Serious Adverse Event: Immediately Notify District Office for Case Investigation

Brief narrative of caregiver/client complaint (*Use additional sheet if needed):*

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Were there any other similar AEFIs reported in the facility in the past 30 days? ☐ Yes ☐ No (If yes, specify)

_____
_____
_____
_____

Patient name & surname: _____ EPID Number: _____

SECTION D: PREVIOUS HISTORY

History of previous reactions to immunisation/treatment:

_____

_____

_____

_____

SECTION E: PRELIMINARY ASSESSMENT AND ACTIONS AT THE TIME OF REPORT

(Tick (✓) boxes that apply)

Is this event a serious AEFI? ☐ Yes ☐ No

If Yes, tick ***(√)*** in the appropriate box below

☐ Death ➔ Date of death (DD/MM/YYYY): __ __ / __ __ / __ __ __ __ ➔ Autopsy: ☐ Yes ☐ No ☐ Unknown

☐ Hospitalisation ➔ Date of admission (DD/MM/YYYY): __ __ / __ __ / __ __ __ __

➔ Name of hospital: _____ Hospital number: _____

☐ Disability

☐ Life threatening

☐ Congenital anomaly

SECTION F *(If applicable)*: WHAT WAS THE <u>OUTCOME</u> OF THE CASE FOLLOWING THE SUSPECTED AEFI?

(Tick (✓) boxes that apply)

☐ Recovering

☐ Recovered fully (no complications)

☐ Recovered with sequelae Specify: _____

☐ Not Recovered

☐ Died

☐ Unknown

SECTION G: FIRST DECISION MAKING LEVEL TO COMPLETE

Case investigation needed: ☐ Yes ☐ No

District Office notified: ☐ Yes ☐ No

If yes, date notified (DD/MM/YYYY):
__ __ / __ __ / __ __ __ __

Date investigation planned (DD/MM/YYYY):
__ __ / __ __ / __ __ __ __