



Report of Suspected Adverse Reaction to Vaccines

ADR Report No. _____

Date of notification: ___ / ___ / 2009 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: _____