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*:** _____

***Patient's full Address*:** _____

_____

Telephone: _____

Sex: ☐ M ☐ F Currently pregnant: ☐ Yes ☐ No

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

OR Age at onset: _____*Years* _____*Months* _____ *Days*

***Reporter's Name*:** _____

Institution: _____

Post & Department: _____

Address: _____

_____

Telephone & E-mail: _____

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 ≥ 38ºC
☐ 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***