COVID-19 vaccine:

NSW Health adverse event following immunisation case notification form

Instructions

- This form has been designed to collect initial clinical information regarding an Adverse Event Following Immunisation (AEFI) related to COVID-19 vaccination.
- The information provided will be used to investigate the reported adverse event following immunisation and will be reported to the Therapeutics Goods Administration to support vaccine safety surveillance.
- The form should be completed by a health professional and submitted by email on MOH-covidaefi@health.nsw.gov.au. Alternatively, cases can be notified by phone to the local Public Health Unit on **1300 066 055**.
- The Public Health Unit may contact you during business hours for further information regarding this case notification.

Vaccinated person's details		
Surname		
First name		
Date of birth		
Age		
Gender	Male	☐
	Female	☐
	Other	☐
Street address		
Postcode		
Suburb		
State		
Phone number		
Aboriginal status: Is the person of Aboriginal or Torres Strait Islander origin?	☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, both Aboriginal and Torres Strait Islander	

Reporter details	
Surname	
First name	

Practice name (if relevant)		
Street Address		
Suburb		
Postcode		
Phone – Landline (incl. area code)		
Mobile phone		
Email address		
Fax		
Date of report		
Reporter type	Medical practitioner	☐
	Register nurse	☐
	Vaccinated person	☐
	Parent/guardian	☐
	Other (specify)	
Is the reporter the vaccination provider	No	☐
	Yes	☐

Vaccine details (if known)

Vaccine (brand name)	Dose no.	Batch number	Date given	Time given	Route of administration	Injection site	
					IM ☐ SC ☐ ID ☐	RL ☐ RA ☐	LL ☐ LA☐
					IM ☐ SC ☑ ID ☐	RL ☐ RA ☐	LL ☐ LA☐

Adverse Event Details

Date of onset		
Time of onset		
Description of events, including timeline		
Management of event (tick as many as apply)	None	☐
	Nurse assessment	☐
	GP assessment	☐
	Hospital emergency department	☐

	Hospital admission (specify number of days and date of discharge)		
	Unknown	☐	
	Other (describe)		
Please specify the treatment/care provided (e.g. antibiotics, adrenaline, advice, counselling, etc.):			
Outcome			
Have the symptoms resolved?	Yes (specify date and time resolved)	Date	
		Time	
	No (Symptoms are ongoing as of)	Date	
		Time	
		Describe	
	Unknown	☐	