ZAMBIA REPORTING FORM FOR ADVERSE EVENTS FOLLOWING IMMUNIZATION (AEFI)

AEFI Reporting ID: .....

***Patient name*:**	***Reporter's Name*:** .....
***Patient's full Address*:**.....	Institution : .....
Telephone:	Designation &Department: .....
Sex: ☐M ☐F (if Female, ☐Pregnant ☐Lactating ☐N/A)	Address: ....
***Date of birth (DD/MM/YYYY)*:**	Telephone & e-mail:..... .....
OR Age at onset : ☐☐*Years* ☐☐ *Months* ☐☐☐ *Days*	Date patient notified event to health system (DD/MM/YYYY): .....
OR Age Group: ☐*< 1 Year* ☐ *1 to 5 Years* ☐ *>5 to 18 Years* ☐ *>18 to 60 Years* ☐ *>60 Years*	Today's date (DD/MM/YYYY): .....

Health facility (or vaccination centre) name:

Vaccine							***Diluent***		
Name of vaccine (Generic)	***Brand Name incl. Name of Manufacturer***	***Date of vaccination***	***Time of vaccination***	Dose (1st, 2nd, etc.)	***Batch/ Lot No.***	Expiry date	***Batch/ Lot No.***	Expiry date	Time of reconstitution

Adverse event (s):

☐ Severe local reaction ☐ *>3 days* ☐ *beyond nearest joint*
☐ Seizures ☐ *febrile* ☐ *afebrile*
☐ Abscess
☐ Sepsis
☐ Encephalopathy
☐ Toxic shock syndrome
☐ Thrombocytopenia
☐ Anaphylaxis
☐ Fever≥38°C
☐ Other (specify).....

Date & Time AEFI started (DD/MM/YYYY)**:**
..... ☐☐ Hr ☐☐Min

Describe AEFI (Signs and symptoms):

Serious: Yes / No ; ➔ If Yes ☐ Death ☐ Life threatening ☐ Disability ☐ Hospitalization ☐ Congenital anomaly

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 dates of administration (exclude those used to treat reaction) and other relevant information (e.g. other cases)**.** *Use additional sheet if needed :*

First Decision making level to complete:

Investigation needed: ☐ Yes ☐ No	If yes, date investigation planned (DD/MM/YYYY): .....

National level to complete:

Date report received at national level (DD/MM/YYYY):	AEFI worldwide unique ID**:** .....
Comments:	

**Compulsory field*

All *completed forms should be emailed to the following email:* ***npvu@zamra.co.zm, aefizambia@gmail.com*** ***or*** *WhatsApp:* ***+260 956 521094***

Address: *Zambia Medicines Regulatory Authority, Plot No. 2350/M, Off KK International Airport Road, P. O Box 31890 Lusaka, Zambia*