Vancouver CoastalHealth
Promoting wellness. Ensuring care.

DRAFT

PARIS
PRIMARY ACCESS
Regional Information System

IMMUNIZATION ADVERSE EVENT REPORT FOR 24/05/2005

Client's Name:	Paris ID:	PHN:	DOB:	Gender:
			Parent/Guardian:	

Name of Client's Physician:	Address:	Telephone:

Immunization Adverse Event

Reaction Reported Date

Vaccine Information

Name of Person Who Administered Vaccine

Last Name

Given Name(s)

Date Vaccine(s) Administered

Agent or Vaccine 1	Agent or Vaccine Given
Manufacturer	
Lot No.	Site
Indicate which Dose in Series	

Agent or Vaccine 2	Agent or Vaccine Given
Manufacturer	
Lot No.	Site
Indicate which Dose in Series	

Agent or Vaccine 3	Agent or Vaccine Given
Manufacturer	
Lot No.	Site
Indicate which Dose in Series	

Agent or Vaccine 4	Agent or Vaccine Given
Manufacturer	
Lot No.	Site
Indicate which Dose in Series	

ADVERSE EVENT (REACTION) Report only events which cannot be attributed to coexisting conditions.

Reactions preceded by an astrik(*) must be diagnosed by a physician. Time interval between vaccine administration and onset of each reaction must be recorded as number of minutes, hours or days.
See guidelines for temporal criteria.

FEVER:	# of	Min.	Hrs.	Days
☐ >= 40.5 C (105 F)		☐	☐	☐
☐ 39.0 - 40.4 C (102.2 - 104.9 F)		☐	☐	☐
☐ Temperature not recorded but believed to be very high and accompanied by other programs		☐	☐	☐

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Name of Client's Physician:	Address:	Telephone:

LOCAL REACTION AT INJECTION SITE:	# of	Min.	Hrs.	Days
☐ Redness/swelling/pain lasting 4 to 9 days		☐	☐	☐
☐ Redness/swelling/pain lasting >= 10 days		☐	☐	☐
☐ Redness/swelling >= 5 cm. (2") diameter		☐	☐	☐
☐ Severe pain/swelling past nearest joint		☐	☐	☐
☐ Infected abscess (evidense of acute infection)		☐	☐	☐
☐ Sterile abscess/nodule (no evidence of infection) larger than 2.5cm. (1") in diameter and lasting more than one month		☐	☐	☐

SYSTEMIC REACTION:	# of	Min.	Hrs.	Days
☐ Adenopathy (severe or unusual enlargement or drainage of lymph nodes)		☐	☐	☐
☐ Allergic reaction: (Describe in comment section)		☐	☐	☐
☐ hives		☐	☐	☐
☐ wheezing		☐	☐	☐
☐ localized puffiness		☐	☐	☐
☐ generalized edema		☐	☐	☐
☐ Rash - severe (lasting >= 4 days or requiring hospitalization)		☐	☐	☐
☐ Rash lasting 1 - 3 days		☐	☐	☐
☐ Anaphylaxis requiring emergency intervention		☐	☐	☐
☐ Hypotonic - hyporesponsive episode in child < 2 yrs. old only (decreased muscle tone; loss of colour; turning white or blue; decreased level/loss of consciousness; cardiovascular or respiratory collapse).		☐	☐	☐
☐ Excessive somnolence in child < 2 yrs. old only (prolonged sleeping with difficulty rousing)		☐	☐	☐

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Name of Client's Physician:	Address:	Telephone:

NEUROLOGIC SYMPTOMS/ DIAGNOSIS:	# of	Min.	Hrs.	Days
☐ Screaming episode/persistant crying (inconsolable for at least 3 hrs.) or quality of cry unusual for child and not previously heard by parents.		☐	☐	☐
☐ Convulsion/seizure (muscle contractions and decreased level of consciousness associated with'without fever) and not associated with a fainting episode.		☐	☐	☐
☐ Encephalopathy (focal and diffuse neurologic signs; increased intracranial pressure and/or changes in level of consciousness, with or without convulsions) lasting for one day or more.		☐	☐	☐
☐ Meningitis and/or encephalitis lasting over 24 hrs.		☐	☐	☐
☐ Anaesthesia/paresthesia lasting over 24 hrs.		☐	☐	☐
☐ Paralysis lasting over 24 hrs.		☐	☐	☐
☐ Gullain-Barre Syndrome (progressive weakness of more than 1 limb and generalized hyporeflexia)		☐	☐	☐
☐ Subacute Sclerosing Panencephalitis (SSPE)		☐	☐	☐

MISCELLANEOUS:	# of	Min.	Hrs.	Days
☐ Parotitis (swelling and pain of parotid gland(s)		☐	☐	☐
☐ Orchitis (swelling and pain of testicle(s)		☐	☐	☐
☐ Thrombocytopenia		☐	☐	☐
☐ Severe vomiting/diarrhea (<=3 episodes in a 24 hr. period)		☐	☐	☐
☐ Swollen, painful joints lasting at least 24 hrs.		☐	☐	☐
☐ Other severe or unusual events (specify in comments area)		☐	☐	☐
☐ History of previous reaction (specify)				

Date Vaccine Given

Health Unit/Dept. where reported

COMMENTS Further Describing Adverse Event(s)

OUTCOME To be completed when event(s) resolved or within 30 days of initiation of report

Seen By Physician? ☐ NO ☐ YES Date Admitted

Hospitalized Because of Reaction? ☐ NO ☐ YES Date Discharged

☐ RECOVERED ☐ RESIDUAL EFFECTS (DESCRIBE)

☐ FATAL ☐ UNKNOWN (DESCRIBE)

Comments Related to Outcome

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Client's Name:	Paris ID:	PHN:	DOB:	Gender:
			Parent/Guardian:	
Name of Client's Physician:	**Address:**			**Telephone:**

☐ Freedom of Information Issues Discussed with Client/Parent/Guardian?

Staff Date

Form completed by Date Completed

To be completed by Medical Health Officer after outcome section is completed:

Recommendation Code(s)

☐ 1 = No change in immunization schedule

☐ 2 = Delete pertussis

☐ 3 = Delete pertussis vaccine and do protective antibody/antitoxin levels

☐ 4 = Do sensitivity testing (specify)

☐ 5 = Determine protective antibody/antitoxin levels (specify)

☐ 6 = Discontinue use of vaccine (other than Pertussis) (specify)

☐ 7 = Proceed with immunization using antigens separatly

☐ 8 = Next immunization in an emergency setting

☐ 9 = No more vaccine until preschool age (specify)

☐ 10 = Do not give vaccine again unless circumstances stongly warrant use (specify variance)

☐ 11 = Requires follow up (specify)

☐ 12 = Other (specify)

Recommendation

Consultation with BCCDC requested? ☐ NO ☐ YES

Reason Consultation Requested

Authorized By MHO Date MHO Authorized

When OUTCOME information complete and signed by MHO

☐ Copy to BCCDC, Communicable Disease, Epidemiology Services

☐ Copy to client's physician (According to HU/Dept. Protocal)

Community Follow Up

Community Follow Up ☐ NO ☐ YES

Community Follow Up Following MHO Recommendations

Followed Up By Follow Up Completed Date

---------- **End of Report** ----------