## **CASE REPORTING FORM (CRF)**

To be filled by doctor and sent to District Immunization Officer within 24 hours \*Mandatory Field

**AEFI Case ID: IND (AEFI)**  $/ \underline{S} \underline{T} / \underline{D} \underline{S} \underline{T} / \underline{Y} \underline{R} / \underline{N} \underline{U} \underline{M}$  (from SAFE-VAC, for all vaccines except COVID-19 vaccines) **AEFI Case ID: IND (CO-AEFI)**  $/ \underline{S} \underline{T} / \underline{D} \underline{S} \underline{T} / \underline{Y} \underline{R} / \underline{N} \underline{U} \underline{M}$  (from Co-WIN - SAFE-VAC, for COVID-19 vaccines)

	Section A	: Reporter	and notifier	details
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Name of doctor reporting / filling this form*: Contact phone number*:												Reporting Date:// (date when this form is prepared)																
E mail*:									Date case visited and examined / interviewed:																			
Place of present posting*: Designation*:  Address of present posting:											1	date when the case visited or interviewed)																
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Notified by (Name)*:								Designation of notifier (please circle): ASHA / AWW / Health worker / Government doctor / Private practitioner or hospital / Parent / Community / Media / Others																				
Date notified: / / (date when the case informed to reporting doctor)							Specify:																					
<u> </u>					illeu t	.о тер	OI tillig t	uoci	LOI																			
Address of session site*:							Place of Vaccination*: Govt Health Facility / Outreach / Private Health Facility /																					
Villag			an are	a:								Others (specify):																
Distri		iic.										Source of vaccine: Government supply / Privately purchased / Others (specify):																
State	:															_												
Date	of V	accir	nation	*•	/	/	·														amp	aign (I	MI, Pu	lse P	olio,	, MR, J	E, COV	ID
									_																			
Time	of V	accir	nation	:	_:	AN	л/РМ					Тур	e of	Sess	sion	Site	: Fixe	d / out	reacl	n / mo	bile	/ schc	ool / o	thers	(spe	ecify):_		
Sect	ion	В:	Patie	nt d	etails	S																						
Patie	nt Na	ame	*																									
Date	of B	irth	* DD	/MM	/YYYY						Age	e:		year	rs	Mo	onths	s d	ays				S	Sex*	$\top$	Male	Fen	nale
																									_			
Moth	ner's	Nam	ne																									
Spou																												
				with	landm	ıarks (	(Street	nan	ne, ho	use ni	ımbei	r, ville	age,	bloc	ck, T	ehsil	, PIN	No., Te	eleph	one No	o. et	tc.)						
																									T			
																									4			
P	I	N n in	- renro	ducti	ve age	grou	n·			P	Н	0	N	N	E*	-												
1.	Statı	ıs of	pregr	ancy	at the	time	of vaco										t kno											
					egnan of va	•	the tim	ne o	t vacc	inatio	n:						mon t knov	iths / w	7-9 m	onths								
Secti	on C	: De	tails c	f vac			diluent	t(s) a	admii	nister	ed to								(to b	e fille	d by	MO ir	ncharg	ge or	DIO	of are	a whe	re
			ook pla accine					,														Date 8	չ Time	e of	Т	No. c	f OTHE	ER
administered to this case (write vaccine & Dose no. (birth / zero / 1st / 2nd / 3rd / Manufact							Ratch / Lot			ot	Mfg.		Expiry		vaccine			_	beneficiaries who									
	•		accino tails ir			booster 1 / booster 2						turer / No.*				date date		reconstitution / opening vaccine				received vaccine from <b>SAME</b> vial in						
separate rows)* / campaign)*												vial			1	this session												
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Section D : Details of adverse event(s)									
1. Type of Adverse Event: Serious / Severe									
2. If serious AEFI specify: Death / Hospitalization / Cluster / Persistent or significant disability / Congenital anomaly or birth defect / Media, community or parental concern									
If this is a part of a cluster*: Yes / No / Unknown									
If yes number of other cases in the cluster		Cluster ID (as gener	ated by SAFE-VAC):						
Adverse event(s) - clinical* (TICK AS MANY AS APPLIC	CABLE):								
Severe local reaction Fever		Seizures	☐ Injection site abscess						
Sepsis									
Allergic reaction Anaphylaxis Intussusception Lymphadenitis									
Acute Flaccid Paralysis Hypotonic Hypo-re									
Additional for COVID vaccine									
☐ Joint pain / swelling of recent onset	Painful single lim	nb swelling	☐ Chest pain / fainting / palpitation						
Recent ECG / Echo / angiography changes	☐ Breathlessness /	difficulty in breathing / worse	ening of existing respiratory problem						
Altered sensorium / Loss of consciousness	Acute dissemina	ted encephalomyelitis	Guillain-Barre syndrome						
Meningoencephalitis	☐ Mono-neuropat	hy / Poly-neuropathy	Rashes						
Loss of taste / smell	Acute liver injury	/ Acute Liver Failure	Chilblain-like lesions /vasculitis						
Acute kidney injury / Acute Renal Failure / Hemati	uria / Oliguria / Edem	na of legs / Hypertension	Lymphadenopathy						
Coagulation / bleeding disorder (Thromboembolis	m, Hemorrhage)								
Worsening of existing disease (Cardiac / Respirato	ry / Liver / Kidney / [	Diabetes etc.)	Others (specify)						
Pregnancy related events									
☐ Maternal death ☐ Fetal loss (abortion) ☐ Pre	emature delivery	Still birth Neonatal mo	rtality Congenital anomaly in newborn						
Date & Time of first symptom*: DD / MM / YYYY at _	Date & Time of first symptom*: DD / MM / YYYY at:AM/ PM Hospitalization (In-patient admission)*: Yes / No								
Name and address of hospital:									
Date & Time of hospitalization*: DD / MM / YYYY at:AM / PM Hospital Reg. No. (OPD/Admission/Bed Head Ticket):									
If hospitalized, outcome*: Discharged / Still Hospitaliz	ed / Left Against Me	dical Advice (LAMA) / Abscond	ded / Referred / Death / Brought dead						
Current status of patient*: Recovered completely / re	covered with sequal	ae / still under treatment / de	ath / unknown						
Date & Time of Death*: DD / MM / YYYY (if died) at:AM / PM Post mortem done: Yes / No / Unknown Place of death: Home / Hospital / On the way to hospital / Others Date of Post mortem: DD / MM / YYYY									
Describe AEFI (sequence of events, signs and symptoms after vaccination) *:									
Signature and name of Reporting Medical Officer:									
Section E: Decision making details  District Immunization Officer to complete and submit in SAFE-VAC / Co-WIN SAFE-VAC (for COVID-19 vaccines) within 24 hours of receiving the above information. SAFE-VAC: <a href="https://safevac.mohfw.gov.in">https://safevac.mohfw.gov.in</a> ; Co-WIN - SAFE-VAC: <a href="https://www.cowin.gov.in">https://safevac.mohfw.gov.in</a> ; Co-WIN - SAFE-VAC:									
Date report received at District level:/	_/								
Date investigation planned:/	_/								
DIO/ District Nodal Person (Officer forwarding this r			Mobile No*:						
Name         Designation         Mobile No*:           Email id*:         Signature         Date/ Seal:									
Complete Office address (with Pin code)									
For any support or h	ole write to acfii	ndia@gmail.com: safevac.c	shi@gmail.com						