# **CASE REPORTING FORMAT**



### **Case Reporting Format (CRF)**

- Filled by MO in cases of serious and severe AEFI.
- With in 24 hours of notification i.e. the event coming into the notice of the health care system.
- Sent to the DIO office, further shared with State and National in next 24 hours.
- Contains two sections:
  - Details of notifier, reporter, patient, session site, vaccine details, reason for reporting, status, hospitalization, post mortem, event signs and symptoms
  - Details of date and time of receipt of CRF at district, DIO details, date of forwarding of CRF to state and national level
- The details are uploaded in the SAFE-Vac application by the office of the DIO
- A scanned copy of the filled CRF is attached along with it.

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AEFI Re	porti	ng	ID	: 18	ID (	AEF	i)/.			DIS_	12						-	-	d b	y C	00)						
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State									Dist	rict																	
Block/ Ward								Vill	age/	Urba	n Are	ea															
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Special Immunization Week

# SAFE-VAC

## Surveillance and Action For Events following vaccination

- Online application for AEFI surveillance in India.
- All the formats and documents related to serious, severe AEFI cases are to be uploaded to SAFE-Vac along with being mailed to aefiindia@gmail.com
- Data entry is done at the office of the DIO.
- Ensures continuity of data, gives real-time picture of AEFI surveillance in the given state/district, prevents data loss.

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

#### AEFI Reporting ID : IND (AEFI) /\_\_\_ST\_ / DIS\_ / \_YR \_ / \_NUM\_ (To be allotted by DIO)

Section A (To be submitted by MO within 24 hours of case notification to DIO)

District

Block \*/ Ward

State

Village/ Urban Area

Name of Reporting MO (person filling this form) *:		Today's Date:													
Posted at*: Designation*:		Time of preparing this form: AM / PM													
Contact phone number* : E mail*:		Date case visited and examined/interviewed:													
Notified by (Name)* : Date notified to MO: / /	fied by (Name)* : Designation (please circle) practitioner/community/ r notified to MO://														
Patient Name*															
Date of Birth * DD/MM/YYYY A	ge(in Month): M	onths Sex* Male Female													
Mother's Name*															
Father's Name*															
Complete Address* of the Case with landmarks (Street n	ame, house number, village, blo	ck, Tehsil, PIN No., Telephone No. etc.)													
P I N - P H	O N E* -														

Date of Vaccination*: Time of Vaccination::	// AM	/PM		_							ss of session s / Block/ Distr									
<b>Session</b> : Routine (including Campaign (SIA)-IPPI/MR/JE/ Other		pecify	/):							Place o	of Vaccination Health Facili	<b>1*:</b> Go				Faci	lity	/Outi	reach /	
Name of vaccines received (write vaccine & diluent details in separate rows)*	eceived (write vaccine & Dose no. luent details in separate 1 <sup>st</sup> /2 <sup>nd</sup> /etc * Name of Batch															ate c enin f via	g	bei wh vac	of <b>OTH</b> neficiar o receit cine fr <b>AME</b> vi	ies ved om
Date of first symptom*	1	D	D	м	м	Y	Y	Y	Y	Time	of first symp	tom	н	н	м	м	(	АМ	РМ	)
Hospitalization*: No/Yes -	Date	D	D	м	м	Y	Y	Y	Y	Time	of hospitaliza	tion	н	н	м	м	(	АМ	PM	)
Name and address of hospital	(if hospitali	zed):																		

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Current status (encircle)*		Red	cove	ere			-		ll Hospitalized / Recovered & Dis nd discharged / Left Against Mec	-	-		-	-	hospit	alize	d
If died, Date of Death	D	D	м	м	Y	Y	Y	Y	Time of Death	Н	Н	М	М	(	AM	PM	)
Post mortem done? YES / NO/Unknown If yes, then write date post mortem done.	D	D	М	м	Y	Y	Y	Y	If not done, but planned, write date planned	Н	Н	М	М	Y	Y	Y	Ŷ
Describe AEFI (signs and symptoms)*:																	
Suspected adverse event(s)* (TICK AT LEA	ST (	DNE	<b>=</b> ):														
□ Severe local reaction       □ Seizures         ○ >3 days       ○ febrile         ○ beyond nearest joint       ○ afebrile         □ Abscess       □ Sepsis       □ Encephalopate	hy		Тол			-			e 🗌 Thrombocytopenia 🔲 Ana					-			
☐ Fever≥39°C (102°F) ☐ Hypotonic Hypo re	-			-		-	-		Acute Flaccid Paralysis S	uddei	n Une	xplair	ned D	eath	Syndr	ome	
Death due to any reason other than above	_		-						Disability								
<ul> <li>Hospitalization due to any reason other the second s</li></ul>				-	-		• • • • •										
							RM	FO	R EACH CASE IN A CLUSTER)								
Signature and name of Reporting Medical	Offi	cer	:														

## **Section B:** District Immunization Office to complete and forward to state and national level within 24 hours of receiving the above information

Date case reporting form received at the district: / /
Investigations needed: Yes No Reason:
If yes, date investigation planned:// /
DIO/ District Nodal Person (Officer forwarding this report)
NameDesignationMobile
No* Fax No Landline (with STD code) Fax No
Email id* Complete Office address (with Pin code)
Signature/ Seal
To be sent to : State Immunization Officer &
Deputy Commissioner (UIP),
Immunization Division of Govt. of India, MOHFW,
Nirman Bhawan, New Delhi – 110108. Fax No. – 011 23062728 / e mail: aefiindia@gmail.com
Section C: State level to complete
Date report received at state level / / /
Remarks:

Section D: National level to complete
Date report received at national level / / /
Remarks:



#### Preliminary and Final Case Investigation Formats (PCIF/FCIF)

- After CRF is submitted to district, PCIF and FCIF are filled by DIO/District within 10 and 70 days of notification respectively.
- Information regarding:
  - vaccines administered,
  - history, examination of the patient,
  - cold chain,
  - vaccination practices,
  - community information
- Any hospital/ investigation records, post mortem reports, Verbal Autopsy reports are to be collected.

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Hospitalization No/ Yes -	Date	D	D	~	т м	۲	۲	۲	۲		-	Time	e of ho	ospita	alizat	ion	н	н	м	м	¢	АМ	PM	,



#### Day 1- 25/10/2012

 Dr Anand, a paediatrician at the private Dinaram Hospital was called to the casuality at 9:45 pm on 25/10/2012 to manage a two months old girl child named Anchal Thomas. The child was febrile and the parents reported that she had two episodes of seizures since morning. They also reported that the child had received vaccinations in the morning at 9:25 am in the sub centre located in their village. The child was vaccinated with DPT, Hep B and OPV first dose.

- At around 2:30 pm, the child was found to have high grade fever. The mother gave the child paracetamol syrup as advised by the ANM and cold sponging. At that time the child started having tonic clonic movement of all limbs for a few minutes with up rolling of eyes. The child was quiet after that and was not easily responding to the mother as before. The fever came down after about an hour.
- At around 8:00-8:30 pm the fever started increasing and at around 9:00, she again had the same episode as in the afternoon.



#### **Case Study- Anchal - 2**

- On examination, Dr Anand found the child was having high-grade fever of 1030 C. He admitted the child for treatment. He administered antipyretics and antibiotics intravenously. Continuous temperature charting was advised and the parents were asked to continue cold sponging to ensure the fever was not too high.
- Dr Anand then called Dr Raghavendra Yadav, DIO of the district and informed him of the case and the details as given by the father. The child was born on 22/08/2012 at PHC Regharpura. The child stays with her parents (Vishal Thomas and Annie Thomas) in village Sabarvihar, Block Jangdiwadi, Palam - 889217.
- Dr Yadav thanked Dr Anand for reporting the case and noted the case details. He requested Dr Anand to inform him before the child gets discharged. He said that he will send a junior doctor with a blank reporting format to help him report the case the next day.

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											Sec	ctio	n A	(To b	e sub	omitt	ed by	/ MO	with	in 24	hour	s of a	case i	notifi	catio	n to l	210)
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Blo	Block/Ward : JANGIWADI       Village/Urban Area : SABARVIHAR         Name of Reporting MO (person filling this form) : Govt Dr.       Today's Date:26/10/2012																										
Nar	ne of																-	Foda	y's Da	ate:20	5/10/	2012	2				
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Date of Vaccination: 25 /10 Time of Vaccination: 09 : 25	-									Addres	ss of session s	site: <mark>s</mark>	ABAI	RVIH	HAR H	ISC			
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Name of vaccines received (write vaccine & diluent details in separate rows)	eceived (write vaccine & Dose no. iluent details in separate ows) Dose no. (zero/ 1 <sup>st</sup> /2 <sup>nd</sup> /etc. Name of Batch Manufacturer N														ор	ate of ening f vial	b w v	enefic ho rec	DTHER ciaries ceived from vial
DPT	BL04	8/12	JAN-12	DEC	C-13				7										
OPV	186		JAN-12	DEC	C-14				2										
HEPATITIS-B	1		SHA	INA	BI	logi	CALS	н	BVOC	)4A12	FEB-12	JAN	I-14	,			4		
Date of first symptom		2	0	2	0	1	2	Time	e of first symp	otom	1	4	3	0	PN	,	)		
Hospitalization: Yes - Dat	te	2	5	1	0	2	0	1	2		of hospitaliza		2	1	4	5	PN	,	)
Name and address of hospital	(if hospitali	zed):	DINAR	RAM	но	SPITA	<b>AL</b>	I		1				I		I I			

Current status (encircle)		Red	cove	ere					II Hospitalized/ Recovered & Dis nd discharged / Left Against Med						hospit	alize	d
If died, Date of Death	D	D	м	м	7 Y	Y	Y	Y	Time of Death	Н	н	М	М	(	AM	PM	)
Post mortem done? YES / NO/Unknown If yes, then write date post mortem done.	D	D	м	м	1 Y	Y	Y	Y	If not done, but planned, write date planned	Н	Н	м	м	Y	Y	Y	Y
Describe AEFI (signs and symptoms): 2 MONTHS OLD CHILD ADMITTED WITHHIG VACCINIATED AT 09.25AM FOR 1 <sup>ST</sup> DOSE C AROUND 14.30PM ALONG WITH TONIC CL AROUND 20.00-20-30PM THE CHILD GOT F	OF D	РТ, IC С	OP ON	νν, Ινι	HEP JLSI	P-B I ONS	N T 5. N	НЕ 10Т	SAME DAY MORNING FOLLOW HER GAVE PARACETAMOL SYN	VED	вү н	IGH (	GRAD	E FE	VER		
Suspected adverse event(s) (TICK AT LEAS	το	NE)	:														
<ul> <li>Severe local reaction</li> <li>Seizures</li> <li>Seizures</li></ul>																	
	hy		Тох	kic	shoc	k sy	ndr	ome	e 🗌 Thrombocytopenia 🔲 Ana	phyla	ixis	🗌 In	tussus	scepti	on		
☐ Fever≥39°C (102°F) ☐ Hypotonic Hypo re	espo	nsiv	ve E	Epis	sode	(HF	IE)		Acute Flaccid Paralysis S	udder	n Une	explai	ned D	eath	Syndr	ome	
<b>Death due to any reason other than above</b>	- sp	ecif	f <b>y</b>				• • •										
☐ Hospitalization due to any reason other th	an	abo	ve-	$\mathbf{sp}$	ecify	7	• • • • •		Disability								
Cluster – is this case part of a cluster Yes	/ N	<b>o /</b> 1	Unk	kno	own												
If yes no of other cases in the cluster	<u>(US</u>	SE S	EP/	<u>4R</u>	ATE	FOI	RM	FO	<u>R EACH CASE IN A CLUSTER)</u>								
Signature and name of Reporting Medical	Offi	cer	:														



#### Case Study-b/o Jameson

 3 day old (date of birth: 27/04/2013) female baby of Jameson, resident of village Champer, block Gola, district Ramgarh, state Cita, received BCG on 29/04/2013 at 9:15 am at subcenter. After that 1 hr baby went home with mother. The child was fine subsequently. According to mother, she breast fed the child as usual and child slept after feeding. At around 3 am mother noticed that child was not moving and apparently dead.

- The case was informed by ANM Sulekha Kumari on 30/04/2013 to medical officer (Dr Toppo) of PHC at Champer. No post mortem was done.
- The vaccine BCG given was manufactured by Sab India Ltd., batch no. 0034S1077, manufacturing date- March 2012 with expiry date of Feb 2014. The BCG diluents used was manufactured by Zoya Laboratories, ABC, batch no. B122998, manufacturing date- oct 2012 with expiry of sept 2015.
- Medical officer also informed DIO, Dr Prasad about the case.



- CRF to be filled by MO in all cases of serious and severe AEFI within 24 hours of notification
- Filled CRF to be shared with District Immunization officer.
- Starred (Mandatory) fields to be filled by collecting relevant information.
- MO to assist in investigation by collecting the following information for the filling of PCIF and FCIF by the district:
  - vaccines administered,
  - history, examination of the patient,
  - cold chain,
  - vaccination practices,
  - community information
  - Any hospital/ investigation records, post mortem reports, Verbal Autopsy reports are to be collected and shared with district



## Thank you

AEFI reports to <u>aefiindia@gmail.com</u>