## **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)

AEFI Case ID						<u>DS</u>	<u> </u>	<u>Y R</u> /	<u>N</u>	<u>U</u> N	<u> </u>	om (	Co-WIN	I - S/	\FE-\	VAC,	for (	COVI	D-19	9 vac	cine	<u>(s)</u>	
Section A: Repor	ter a	nd n	otifie	er det	ails																		
Name of doctor reporting / filling this form*: Contact phone number*:												Reporting Date://(date when this form is prepared)											
E mail*: Place of present posting*: Designation*:						:						Date case visited and examined / interviewed:											
Address of present posting:								(date when the case visited or interviewed)															
Notified by (Name)*:  Date notified: / /								Designation of notifier (please circle): ASHA / AWW / Health worker / Government doctor / Private practitioner or hospital / Parent / Community / Media / Others Specify:									t						
(date when the case informed to reporting doctor)																							
Address of session site*:							Place of Vaccination*: Govt Health Facility / Outreach / Private Health Facility /																
Village or Urban area	a:							Othe	ers (s	pecif	y):												
Block Name:								Sour	ce of	f vaco	ine: G	overr	nment su	ylqqı	/ Priv	/ately	purc	hased	/ Ot	hers (	speci	fy):	
District:								Source of vaccine: Government supply / Privately purchased / Others (specify):															
State:								Vacc	inati	ion in	1*: Roi	ıtine	Immuniz	ation	ı / Ca	mnai	gn (M	I Puls	e Po	lio M	R IF	COVI	<u> </u>
Date of Vaccination*://						Vaccination in*: Routine Immunization / Campaign (MI, Pulse Polio, MR, JE, COVID																	
								19) / Others (specify):															
Time of Vaccination: : : AM/PM							Type of Session Site: Fixed / outreach / mobile / others (specify):																
Section B : Patier	nt de	tails	•				I																
Patient Name*																							
Date of Birth * DD/	/MM/	YYYY					Age	e:	y	ears <sub>-</sub>	Mo	onths	5 day	/S				Se	x*	Ma	le	Fem	ale
Mother's Name																							
Spouse/Father's Nam	ne*																						
Complete Address* with landmarks (Street name, house number							ımber	, villa	ge, b	olock,	Tehsil,	PIN	No., Tele	ephor	ne No	. etc.	)						
P I N -						Р	Н	0	N	E*	-												
For women in reprod 1. Status of pregna 2. If Yes, duration of 3. Lactating at the	ancy a of pre time	it the gnan of vac	time o cy at tl	of vaccir he time on:	of vaco			1- Ye	3 mc s /	onths No /	Don't	mon knov	ths / 7- N										
Section C : Details of vaccination took place		ine(s)	ana a	iluent(s	) admii	nistere	α το τ	ne Al	EFI C	ase a	uring t	nis s	ession (t	o be	тшеа	by IV	io inc	narge	orL	ΙΟ ΟΤ	area	wner	е
Name of vaccines administered to thi case (write vaccine diluent details in	is	Dose no. (birth / zero / 1st / 2nd / 3rd / booster 1 / booster 2 / campaign)*  Name Manufact Brand N					nufact	turer / Batch / Lot			ot	Mfg. date			Date & Time of vaccine reconstitution / opening vaccine			No. of <b>OTHER</b> beneficiaries who received vaccine from <b>SAME</b> vial in					
separate rows)*		/ campaign)*															vial			this session			

Section D : Details of adverse	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*: \	res / No / Unknown										
If yes number of other cases	in the cluster	<u></u>	Cluster ID (as gener	rated by SAFE-VAC):							
Adverse event(s) - clinical* (	TICK AS MANY AS APPI	LICABLE):									
Severe local reaction	☐ Fever		Seizures	☐ Injection site abscess							
Sepsis											
Allergic reaction	Allergic reaction Anaphylaxis Intussusception Lymphadenitis										
Acute Flaccid Paralysis											
Additional for COVID vaccine	2										
☐ Joint pain / swelling of re	☐ Joint pain / swelling of recent onset ☐ Painful single limb swelling ☐ Chest pain / fainting / palpitation										
Recent ECG / Echo / angio	Recent ECG / Echo / angiography changes										
☐ Altered sensorium / Loss	of consciousness	Acute dissemina	ted encephalomyelitis	Guillain-Barre syndrome							
Meningoencephalitis		Mono-neuropa	thy / Poly-neuropathy	Rashes							
Loss of taste / smell		Acute liver injur	y / Acute Liver Failure	Chilblain-like lesions /vasculitis							
Acute kidney injury / Acu	te Renal Failure / Hema	ituria / Oliguria / Eden	na of legs / Hypertension	Lymphadenopathy							
Coagulation / bleeding dis	sorder (Thromboembol	ism, Hemorrhage)									
☐ Worsening of existing disease (Cardiac / Respiratory / Liver / Kidney / Diabetes etc.) ☐ Others (specify)											
Pregnancy related events											
☐ Maternal death ☐ Feta	al loss (abortion) 🔲 P	remature delivery	Still birth Neonatal mo	ortality Congenital anomaly in newborn							
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):											
				ded / Referred / Death / Brought dead							
Current status of patient*: Re	ecovered completely / I	recovered with sequal	ae / still under treatment / de	eath / unknown							
Date & Time of Death*: DD / MM / YYYY (if died) at:AM / PM Place of death: Home / Hospital / On the way to hospital / Others  Post mortem done: Yes / No / Unknown Date of Post mortem: DD / MM / YYYY											
Describe AFEL (sequence of events, signs and symptoms after vaccination) *:											
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											
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.nhp.gov.in">https://safevac.nhp.gov.in</a> ; Co-WIN - SAFE-VAC:											
Date report received at District level:/											
Date investigation planned:/											
DIO/ District Nodal Person (Officer forwarding this report)											
Name         Designation         Mobile No*:           Email id*:         Signature         Date/ Seal:											
Complete Office address (with Pin code)											
	For any support or	help, write to: aefii	ndia@gmail.com; safevac.	chi@gmail.com							