health
Department: Health
REPUBLIC OF SOUTH AFRICA

COVID-19

CASE REPORTING FORM (CRF) FOR SUSPECTED ADVERSE EVENTS OF SPECIAL INTEREST (AESI)

EPID Number: S O A - | | | | - | | | | - | | | | - | | | | |

Country - Province - District - Year - Case no

Today's date: D D / M M / Y Y Y Y

All fields in this form are mandatory, unless indicated 'if applicable'. Provide the requested information or tick the appropriate box.

Date received	*Level*	*Signature*
	Private	
	District	
	Province	
	National EPI	
	National SAHPRA	

(For Office use only)

SECTION A: IDENTIFYING INFORMATION

Vaccine recipient name & surname: _____

If child: Caregiver's name & surname: _____

Vaccine recipient's residential address: _____

_____

Mobile no: _____ Telephone no: _____

Sex: ☐ M ☐ F ☐ Other *If applicable:* ☐ Pregnant ☐ Breastfeeding

Date of birth: D D / M M / Y Y Y Y

OR Age at onset: ☐☐ Years ☐☐ Months ☐☐☐ Days

OR Age group: ☐ 0 - <1 year ☐ 1 - 5 years ☐ >5 – 18 years ☐ >18 – 60 years ☐ >60 years

If applicable: Gestation: ☐ Full-term ☐ Premature

AESI Reporter's name & surname:

_____

Designation/Position:

_____

Institution & Department:

_____

_____

Telephone no: _____

Mobile no: _____

E-mail: _____

Date patient notified event to health system:
D D / M M / Y Y Y Y

SECTION B: ADVERSE EVENT(S)OF SPECIAL INTEREST (AESI)

Date & time AEFI started: D D / M M / Y Y Y Y ☐☐ Hr ☐☐ Min

Adverse event (s): (Tick (✓) all boxes that apply)

- ☐ Acute aseptic arthritis
- ☐ Acute cardiovascular injury
- ☐ Acute disseminated encephalomyelitis
- ☐ Acute liver injury
- ☐ Acute kidney injury
- ☐ Acute respiratory distress syndrome (Microangiopathy, Heart failure, Stress cardiomyopathy, Coronary artery disease Arrhythmia, Myocarditis)
- ☐ Anaphylaxis
- ☐ Anosmia, ageusia
- ☐ Chilblain-like lesions
- ☐ Coagulation disorder (Thromboembolism, Haemorrhage)
- ☐ Enhanced disease following immunisation
- ☐ Erythema multiforme
- ☐ Generalized convulsion
- ☐ Guillain Barré Syndrome
- ☐ Meningoencephalitis
- ☐ Multisystem inflammatory syndrome in children
- ☐ Single organ cutaneous vasculitis
- ☐ Thrombocytopenia
- ☐ Other (specify): _____

Describe vaccine recipient's AESI signs and symptoms. Use additional sheet if needed

_____

_____

_____

_____

Past medical history (including history of previous similar reactions or other allergies), concomitant medication and any other relevant information (e.g. other cases). Use additional sheet if needed

_____

_____

_____

_____

Patient name & surname: _____ EPID Number: _____

SECTION C: PRELIMINARY ASSESSMENT AND ACTIONS AT THE TIME OF REPORT

Did this AESI cause? ☐ Death ☐ Hospitalisation ☐ Disability ☐ Life threatening ☐ Other important medical events (Specify): _____

Outcome at the time of reporting: ☐ Recovering ☐ Recovered fully (no complications) ☐ Not Recovered ☐ Unknown

☐ Recovered with sequelae; Specify: _____

☐ Died ➔ Date of death: D D / M M / Y Y Y Y ➔ Full autopsy done: ☐ Yes ☐ No ☐ Unknown

If NO, verbal autopsy done? ☐ Yes ☐ No

☐ Hospitalisation ➔ Date of admission: D D / M M / Y Y Y Y

➔ Name of hospital: _____ Hospital number: _____

Did this person receive a COVID-19 vaccine? ☐ Yes ☐ No ☐ Unknown **If Yes, Complete Section E below**

SECTION D: VACCINE INFORMATION (Please attach a copy of the Vaccination Record)

Health facility / vaccination center name: _____ ☐ **DoH** ☐ **Private** ☐ **NGO**

Address / location: _____

COVID-19 vaccine administered								Diluent *(if applicable)*		
Vaccine given (Use trade name)	Manufacturer	Dose number (1st, 2nd)	Date vaccinated	Time vaccinated	Batch/ Lot number	Expiry date / Manufacture date	Immunisation record number	Batch/ Lot number	Expiry date	Date & time of reconstitution

Consumables used	**Needles**	Size: _____ Batch: _____ Expiry date: _____
	Syringes	Size: _____ Batch: _____ Expiry date: _____

Details of Non-COVID19 vaccines received in the last 1 year (Use additional page if there are more vaccines)

Consumables used (unless pre-filled)	**Needles**	Size: _____ Batch: _____ Expiry date: _____
	Syringes	Size: _____ Batch: _____ Expiry date: _____

SECTION E: FIRST DECISION MAKING LEVEL TO COMPLETE

For ALL AESI cases including COVID-19 vaccinated and unvaccinated

AEFI confirmation initiated: ☐ Yes ☐ No **If YES**, confirmation done by Dr/Mr/Ms _____

Date investigation planned: D D / M M / Y Y Y Y

Is this AESI linelisted? ☐ Yes ☐ No

For COVID-19 vaccinated cases: Field investigation planned with AESI investigation form? ☐ Yes ☐ No

If YES, date planned: D D / M M / Y Y Y Y

SECTION F: NATIONAL LEVEL TO COMPLETE

Date report received at National Level: D D / M M / Y Y Y Y | **AESI worldwide unique ID:** _____

Comments: _____

_____

IMPORTANT: Email this form within 24 hours to AEFI@health.gov.za

AND copy the EPI District Surveillance Officer