Government of **Western Australia**
Department of **Health**
WA Vaccine Safety Surveillance

WAVSS

WA Vaccine Safety Surveillance: Adverse Reaction Reporting Form

Date received by WAVSS ___/___/_____
dd / mm / yyyy

☐☐☐☐ – ☐☐☐☐☐
Notification ID

You may report adverse events after immunisation:

Online: www.wavss.health.wa.gov.au
Phone: 08 9321 1312 (8:30am – 4:30pm)
Fax this form to: 08 9426 9408 (24 hours)
Post this form to: Central Immunisation Clinic,
PO Box 8172, Perth Business Centre, WA 6849
Using regular post may delay receipt of report by several weeks.

1.Vaccinated person's details

☐ Miss ☐ Mrs ☐ Ms ☐ Mr

First name _____

Last name _____

Date of birth ___/___/_____ or Age _____ (DOB unknown)
dd / mm / yyyy *days/weeks/months/years*

Gender ☐ male ☐ female ☐ unknown

Ethnicity ☐ Aboriginal ☐ Non-Aboriginal
☐ Torres Strait Islander ☐ unknown

Street address _____

Suburb _____

State _____ Postcode ☐☐☐☐

Phone (if landline, provide area code) _____

Medicare number (10 +1 digits) ☐☐☐☐☐☐☐☐☐☐ + ☐

Medication history _____

Underlying medical conditions _____

Previous reaction(s) to vaccination _____

2. Vaccination provider's details

☐ Prof ☐ AProf ☐ Dr ☐ Miss ☐ Mrs ☐ Ms ☐ Mr

First name _____

Last name _____

Profession

☐ Medical practitioner ☐ Registered nurse

☐ Other health professional, please specify _____

Clinical setting

☐ GP office ☐ Council clinic

☐ School vaccination program ☐ Hospital

☐ Central Immunisation Clinic ☐ Unknown

☐ Other, please specify _____

Address where vaccine was administered:

Practice name _____

Street address _____

Suburb _____

State _____ Postcode ☐☐☐☐

Phone (if landline, provide area code) _____

3. Reporter's details

☐ As for vaccination provider OR

☐ Prof ☐ AProf ☐ Dr ☐ Miss ☐ Mrs ☐ Ms ☐ Mr ☐ Mstr

First name _____

Last name _____

Practice name _____

Street address _____

Suburb _____

State _____ Postcode ☐☐☐☐

Phone (if landline, provide area code) _____

Email _____

Reporter type:

☐ Medical practitioner

☐ Registered nurse

☐ Vaccinated person

☐ Parent/guardian of vaccinated person

☐ Other health professional, specify _____

4. Vaccine(s) administered related to adverse event

Vaccination date ___/___/_____
dd / mm / yyyy

Vaccination time ___ : ___ am/pm
hour min

Site LEFT	Site RIGHT	Vaccine name	Dose number	Batch number
ARM LEG	ARM LEG			
ARM LEG	ARM LEG			
ARM LEG	ARM LEG			
ARM LEG	ARM LEG			
ARM LEG	ARM LEG			
ARM LEG	ARM LEG			
ARM LEG	ARM LEG			
ARM LEG	ARM LEG			
ARM LEG	ARM LEG			
ARM LEG	ARM LEG			

PLEASE TURN OVERLEAF

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5. Reaction and treatment

Time elapsed from time of vaccination to first symptom:

_____ _____ _____ _____
hours *mins* *days* *weeks*

Detailed description of the reaction, including timing of events:

_____

_____

_____

How was the adverse event managed? *(Tick all that apply)*

☐ None or symptomatic (e.g. paracetemol) only

☐ Nurse assessment

☐ GP assessment

☐ Hospital emergency

☐ Hospital admission, specify number of days _____ days

☐ healthdirect Australia

☐ Central Immunisation Clinic

☐ Unknown

☐ Other, specify _____

Describe the medical care sought or received:

_____

_____

How long did the symptoms last?

_____ _____ _____ _____
hours *mins* *days* *weeks*

Have the symptoms resolved? ☐ yes ☐ no, the symptoms are ongoing ☐ unknown

Describe any symptoms the vaccinated person is still experiencing:

_____

_____

_____

I, the reporter confirm that I understand that I may be contacted by the Western Australian Department of Health regarding this event.

Signature _____ Date ___/___/____

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