VACCINATION MEDICATION ERROR REPORTING FORM

Providers Name:	Phone Number:

1. Details of person reporting this vaccination error

Name: _____

Address: _____

Suburb: _____ Post code: _____ Phone: _____

Reporter type: ☐ GP ☐ Medical Specialist ☐ Medial Practitioner ☐ Nurse RN ☐ Nurse EN
☐ Vaccinated person ☐ Parent ☐ Guardian ☐ Other: _____

2. Details of person who experienced the vaccination error

Name: _____ DOB: ____/____/_____

Address: _____ State: _____

Post code: _____ Home Phone: _____ Mobile: _____

Gender: ☐ M ☐ F ☐ unknown If a child, Parent/Guardian name: _____

3. Details of vaccination error

Please indicate type of error:

☐ Wrong Medication ☐ Wrong dose ☐ Wrong time ☐ Wrong route ☐ Wrong client

☐ Other: _____

4. Vaccine information

Vaccine Administered: _____

Brand/Type: _____ Date: ____/____/_____

Time Administered: ____:____ Batch No: _____ Route: _____

5. Details of what happened and how the error was identified

(For additional space please turn over the page)

6. Did the event impact the client negatively?

☐ Yes ☐ No Date of reaction ____/____/_____ time reaction occurred ____:____

Has an Adverse Event Following Immunisation been completed ☐ Yes ☐ No

Detailed description of the adverse event:

_____

7. Outcome of the event

☐ Event has the potential to cause harm ☐ No harm ☐ Requires monitoring ☐ Harm incurred

8. Could this have been prevented?

☐ Yes ☐ No If so, explain how: _____

On completion, fax this form to 02 5124 9307, or email to: immunisation@act.gov.au

WHAT TO DO IF YOU HAVE A VACCINATION ERROR

Follow your practices clinic procedures for medication errors.

Notify client of mistake and make sure client has no adverse reaction following vaccination error.

If there is an adverse reaction please fill out an Adverse Event Following Immunisation.

Notify ACT Health Immunisation Unit on **5124 9800.**

Fill out the ACT Health vaccination error reporting form.

Fax this form to 02 5124 9307, or email to: immunisation@act.gov.au.

Additional information:

Office use only

ACT CASE NO: _____ SAFEVAC/TGA CASE NO: _____

Date report received: _____/____/_____ Date sent to SAFEVAC/TGA: _____/____/_____

Is this considered a serious vaccination error? ☐ Yes ☐ No

If yes, please specify: _____

Is follow up on patient required? ☐ Yes ☐ No Is follow up with provider required? ☐ Yes ☐ No

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