Northern Territory Government

DEPARTMENT OF HEALTH

BCG INCIDENT AND SIDE EFFECTS REPORTING FORM

This form can be used to report both incidents relating to administration and BCG side effects. An *Adverse Event Following Immunisation form* (AEFI) should also be completed.

DETAILS PLACE GIVEN (eg ASH): ________________

SURNAME: ____________________________ FIRST NAME: ______________________

SEX: M ☐ F ☐ DOB: ___ / ___/ ___ HRN: ________________

DELIVERY: ______ WEEKS: _____ DATE OF BCG: ___ / ___ / ___ BATCH NO: _______

REASON: (Please tick) Indigenous ☐ Living overseas high prevalence country> 3 mths ☐ HCW ☐

Leprosy ☐ Indigenous Community dweller ☐ Defence force ☐ No Reason ☐ Other ______________

1ST PRESENTATION: ___ / ___ / ___ NUMBER OF PRESENTATIONS: ______________

TECHNIQUE INFORMATION

Bleb seen ☐ No Bleb seen ☐ Given ID ☐ Given SC ☐ Given IM ☐

Overdose ☐ Amount _________ Other ___________________________

Eye splash ☐ Goggles worn Y / N 20 minute eyewash Y / N INH given Y / N

Outcome ____

(if there are no complications at this point please complete reporter details and Fax to CDC)

COMPLICATIONS: (Please tick) **AREA INVOLVED**

Axillary Node Enlarged ☐ _______________

Axillary Suppuration Node ☐ _______________

Local Site Abscess ☐ _______________

Local Site with Suppuration ☐ _______________

Local Site secondary Infection ☐ ____________

Disseminated BCG ☐

Keloid ☐

Other (Please state) _________________________

HOSPITALISED: Yes ☐ No ☐

Dates: Admitted: ___ / ___ / ___ Discharged: ___ / ___ / ___

Admitted: ___ / ___ / ___ Discharged: ___ / ___ / ___

Admitted: ___ / ___ / ___ Discharged: ___ / ___ / ___

Other Diagnosis: Yes ☐ No ☐ Scabies ☐ Skin Sores ☐ Other ________

ACTION TAKEN: (Please tick)

Node excision ☐ Local site excision ☐ Drainage (needle or surgical) ☐ Anti TB medication only ☐

Non TB medication only ☐ Non TB medication and other ☐ Observation only ☐Other _____________

SPECIMEN TAKEN: Yes ☐ No ☐

AFB Smear +ve ☐ AFB Culture +ve ☐ *M bovis* ☐ MTB PCR +ve ☐ Resistant to INH ☐

Histology collected Yes ☐ No ☐ Result compatible ☐ not compatible ☐

OUTCOME: Healed ☐ Other____________________________

REPORTER DETAILS Reported by: Name ______________________Signature_______________

Contact Number__________________________Date _____________________

Fax to Darwin CDC: 89228310. Contact TB clinic on 89228804 if more information is required.