**Suspected neurological adverse event following administration of COVID-19 vaccine\***

Local Identification Number: Adverse Event Reference Number:

Patient Initials: Patient Age: Patient Sex:

Ethnicity:

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| **Source of information** |
| Name of the person reporting |  | Position (e.g. specialty and grade) |  |
| Hospital / Practice |  | Email address |  |

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| **Patient Background** |
| Past Medical History: |
| Regular and recent medications: |
| Infectious illness in the last six weeks:  | Yes/ No/ Unsure |
| Other vaccination received in the last six weeks: | Yes/ No/ Unsure |
| Previous adverse neurological reaction to a vaccine: | Yes/ No/ Unsure |
| History of neurological disease (previous or current): | Yes/ No/ Unsure |
| Immunosupression at the time of vaccination: | Yes/ No/ Unsure |
| If Yes to any above, please provide details: |

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| **Patient’s Covid-19 Status** |
| Previous diagnosis of Covid-19: | Yes, once/Yes, more than once/ No/ Unsure |
| If Yes, date of onset: | Date: |
| If Yes, means of diagnosis:  | PCR/ Antibody / Clinical |

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| **Vaccination Details** |
| 1st vaccination: Pfizer-BioNTech/ Oxford- AstraZeneca/ Moderna/ Sinopharm/ Sinovac/ Sputnik V/ Other- specify:Lot number: \_\_\_\_\_ Dose: \_\_\_\_ Route of administration:  | Date:  |
| 2nd vaccination: Pfizer-BioNTech/ Oxford- AstraZeneca/ Moderna/ Sinopharm/ Sinovac/ Sputnik V/ Other- specify:Lot number: \_\_\_\_\_ Dose: \_\_\_\_ Route of administration: | Date: |
| Date of neurological symptoms onset | Date: |

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| **Clinical Features**  |
| Time from onset to peak symptoms (hrs/days): \_\_\_\_\_\_\_\_\_\_ |
| Please provide destription of the adverse neurological event here: |
| Has the patient experienced a similar neurological event before? Yes/No/UnsureIf Yes, please provide details, including the date and suspected triggers: |

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| **Assessment and investigations to exclude other causes** (please indicate which of the following have been considered, and give details at the bottom) |
| **Clinical Assessment** |
| Please list relevant features of history and examination and specify for each | Yes/ No/ Unknown |
| **Laboratory investigations (blood)** |
| Please list relevant investigations and specify for each:Include COVID-19 serology/ PCR | Normal / Abnormal / Unknown / Not done |
| **CSF Biochemistry:** CSF Protein: \_\_\_\_\_\_\_ Serum:CSF Glucose Ratio: \_\_\_\_\_\_\_\_\_CSF RCC: \_\_\_\_\_\_\_\_\_ CSF WCC: \_\_\_\_\_\_\_\_ CSF differential: \_\_\_\_\_\_\_\_\_ Date: ­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_ |
| **CSF Cytology**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **CSF Oligoclonal bands and IgG index** | Normal / Abnormal / Unknown / Not done |
| **CSF Microscopy & culture** | Normal / Abnormal / Unknown / Not done |
| **CSF Virology & Microbiology\***Please list organisms tested: | Normal / Abnormal / Unknown / Not done  |
| **CSF Autoimmune Encephalitis panel**\*\* | Normal / Abnormal / Unknown / Not done |
| **CSF Paraneoplastic panel\*\*** | Normal / Abnormal / Unknown / Not done |
| **\*Please list the pathogens tested:** |
| **\*\*Please list the antibodies tested in the panels, indicating whether tested in serum, in CSF or in both:** |
| Any other relevant laboratory results: |
| **Radiological studies** (if abnormal, give details at the bottom) |
| CT HeadMRI HeadMRI spineWhole body CTPET CT | Normal / Abnormal / Unknown / Not doneNormal / Abnormal / Unknown / Not doneNormal / Abnormal / Unknown / Not doneNormal / Abnormal / Unknown / Not doneNormal / Abnormal / Unknown / Not done |
| **Electrophysiological studies** (if abnormal, give details at the bottom) |
| EEGEMGNCS | Normal / Abnormal / Unknown / Not doneNormal / Abnormal / Unknown / Not doneNormal / Abnormal / Unknown / Not done |
| **Biopsy**  | Normal / Abnormal / Unknown / Not done |
| **Genetic studies** | Normal / Abnormal / Unknown / Not done |
| **Details of any abnormal findings:** |
| **Please describe if any of the findings could explain the aetiology of the event:** |

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| **Treatment** (including dose and duration) |
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| **Patient outcome** |
| Date of last follow-up (if none, write none): |
| Maximum level of care required:Outpatient/ Medical Inpatient/ High Dependency Unit/ Intensive Care Unit |
| Patient alive at last follow-up: Yes/ NoIf No, was the neurological adverse event included on the death certificate: Yes/ No/ UnknownIf relevant, date of death: |
| Outcome at least follow up (circle): Complete resolution / Incomplete resolution / No improvement / Re-occurrence / Other sequalaeIf relevant, time to complete resolution:\_\_\_\_\_\_\_\_\_\_ |
| Modified Ranking Scale: Before adverse event:\_\_\_\_\_\_\_ At the last follow-up: \_\_\_\_\_\_ |
| Details: |

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| **Subsequent COVID-19 Vaccinations** |
| Has this patient received any further COVID-19 vaccines after the development of the neurological adverse event?  | Yes/ No/ Unsure  |
| If Yes: Pfizer-BioNTech/ Oxford- AstraZeneca/ Moderna/ Sinopharm/ Sinovac/ Sputnik V/ Other- specify:Lot number: \_\_\_\_\_ Dose: \_\_\_\_ Route of administration: | Date: |
| If Yes, Outcome: No adverse event/ Re-occurrence of the same adverse event/ Development of another neurological adverse event/ Worsening of previously unresolved neurological adverse event/ Other sequelaeDate the outcome was last known: |
| Other details: |