**Dengvaxia – 10 days post (Q2)**

Q1 Date called

Q2 Name of patient

Q3 Date of birth patient

Q4 Did the patient experience any of the following

|  |  |
| --- | --- |
| ( ) Sore arm (1) | ( ) Headache (6) |
| ( ) Swelling around injection site (2) | ( ) Tiredness, lethargy, malaise (7) |
| ( ) Redness around injection site (3) | ( ) Nausea (8) |
| ( ) Fever (4) | ( ) Diarrhoea (9) |
| ( ) Flu-like illness (5) | ( ) Sore muscles or joints (10) |

Other, please specify (11) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q 5 IF SWELLING : How large was swelling around injection site

( ) Size of 5 cent coin (1)

( ) Size of 10 cent coin (2)

( ) Size of 20 cent coin (3)

( ) Size of 50 cent coin (4)

( ) Larger than the size of a 50 cent coin (5)

Q6 IF REDNESS: How big was the redness around the injection site?

( ) Size of 5 cent coin (1)

( ) Size of 10 cent coin (2)

( ) Size of 20 cent coin (3)

( ) Size of 50 cent coin (4)

( ) Larger than the size of a 50 cent coin (5)

Q7 Did the patient have to miss any of his or her normal daily activities because of the side effects from the vaccine? (TICK all that apply)

( ) Did not miss any activities (1)

( ) Missed work (2)

( ) Missed sport or gym (3)

( ) Missed family activities (4)

( ) Other (5) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q8 Would the patient be happy to have the next dose of the vaccine in 6 months' time?

( ) Yes

( ) No, IF NO please explain why not \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q9 IF YES We will call you again in a week to ask if you have had any side effects from the vaccine.  If you have any severe reactions or serious problems before then, please contact the clinic.

Q 10 Any further comments ? (PTO if need more space )

STAFF MEMBER WHO RANG THE PATIENT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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