Alberta Health Services

Healthy Albertans.
Healthy Communities.
Together.

Canada's Top 100 Employers 2016

[redacted]
Communicable Disease Control
Provincial Population & Public Health, Alberta Health Services
[redacted]
[redacted]

December 6, 2021

Dr. G. Chan
[redacted]

Dear: Dr. Chan,

RE: Adverse Event Following Immunization (AEFI) Reporting – COVID-19 vaccine

Thank you for your recent referrals to the AHS AEFI program. Reporting of unusual events following immunization is an important tool in monitoring vaccine safety, particularly in the current pandemic. Upon reviewing submissions from your office, several have not met reporting criteria as the event could be attributed to a pre-existing condition or the symptom(s) is explained by medical history or recent illness. To support efficient and accurate reporting of AEFI's, the following excerpt from *The Alberta Health Adverse Events Following Immunization policy for Alberta Immunization providers* outlines the submission criteria:

Any "adverse event following immunization" defined as an unfavourable health occurrence experienced by a patient that:

(a) follows immunization,

(b) cannot be attributed to a pre-existing condition, and

(c) meets one or more of the following criteria, as determined by a health practitioner:

(i) the health occurrence is life threatening, could result in permanent disability, requires hospitalization or urgent medical attention, or for any other reason is considered to be of a serious nature;

(ii) the health occurrence is unusual or unexpected, including, without limitation, an occurrence that

(A) has not previously been identified, or

(B) has previously been identified but is being reported at increased frequency;

(iii) the health occurrence cannot be explained by anything in the patient's medical history, including, without limitation, a recent disease or illness, or consumption of medication.

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Prior to submitting an AEFI, please ensure the symptoms meet the criteria as noted above.

Thank you for your support of the Alberta Immunization Program. Questions regarding referrals to the AEFI program may be directed to aefi@ahs.ca or 1-855-444-2324.

Sincerely,

[redacted]

Dr. Kristin Klein
Lead Medical Officer of Health, Communicable Disease Control
Provincial Population & Public Health, Alberta Health Services

Health Canada / Santé Canada

Serious adverse drug reaction reporting form for hospitals

Canada Vigilance - Adverse reaction reporting program

For best results, download and open this form in a PDF reader.

Privacy notice: The personal information you provide to Health Canada is governed in accordance with the *Privacy Act*. We only collect the information Health Canada needs to administer the Canada Vigilance adverse reaction reporting program authorized under the *Department of Health Act*, section 4 and the *Food and Drug Regulations*, Section C.01.020.

Purpose of collection: Health Canada requires this information to assess adverse reaction reports, monitor the safety of health products and enforce relevant legislation where applicable. Personal information may be used to analyze general trends, report to senior management and evaluate related programs and services. Trend and safety data in a de-identified format may be communicated by a variety of risk communication tools and/or responses to inquiries. A subset of de-identified Canada Vigilance adverse reaction reporting program data is made publicly available from the Canada Vigilance adverse reaction online database.

Other uses or disclosures: Personal information may be shared within Health Canada and with the Public Health Agency of Canada, the Canadian Medication Incident Reporting and Prevention System Program (managed in partnership with the Canadian Institute for Health Information, the Institute for Safe Medication Practices Canada, and the Canadian Patient Safety Institute), and international regulatory and health product monitoring authorities, for monitoring adverse reactions. In limited and specific situations, your personal information may be disclosed without your consent in accordance with subsection 8(2) of the *Privacy Act*.

For more information: This personal information collection is described in Info Source, available online at https://www.canada.ca/en/health-canada/corporate/about-health-canada/activities-responsibilities/access-information-privacy/info-source-federal-government-employee-information.html#a26. Refer to the personal information bank HC PPU 417.

Your rights under the *Privacy Act*: In addition to protecting your personal information, the *Privacy Act* gives you the right to request access to, and correction of, your personal information. For more information about these rights, or about our privacy practices, please contact Health Canada's privacy coordinator at 613-946-3179 or hc.privacy-vie.privee.sc@canada.ca. You also have the right to file a complaint with the Privacy Commissioner of Canada if you think your personal information has been handled improperly.

Submission methods

Electronic reporting
If you are interested in submitting reports electronically (e.g. secure file transfer protocol - sFTP) to Health Canada, please email the Canada Vigilance Program at hc.canada.vigilance.sc@canada.ca

Fax
Download, complete and print the Serious adverse drug reaction reporting form for hospitals.
Send by fax at: 1-866-678-6789

Mail it to the Canada Vigilance National Office
Canada Vigilance Program
Health Products Surveillance and Epidemiology Bureau
Marketed Health Products Directorate
Health Products and Food Branch
Health Canada
Address Locator 1908C
Ottawa, Ontario
K1A 0K9

If you have any questions related to mandatory reporting for hospitals, you may contact the Canada Vigilance Program by:
Email: hc.canada.vigilance.sc@canada.ca
Toll-free telephone: 1-866-234-2345

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Canada

[redacted]

2 | Serious adverse drug reaction reporting form for hospitals

* = required, if known (if information is in the control of or reasonably accessible by the hospital for mandatory reporting)
** = required (hospital is exempt from mandatory reporting if this information is unavailable)
Specific field instructions can be found at the end of the form. Submission of a report does not constitute an admission that medical personnel or the suspect product(s) caused or contributed to the serious adverse drug reaction(s).

A. General information

1. Type of report*	2. Health Canada reference no. (for follow-up reports only)
☒ Initial ☐ Follow-up	

3. Organization file no.	4. Date report submitted	5. Documentation date*
	June 23, 2021	June 22, 2021

6. a. Organization contact first name* / b. Last name*	7.a. Phone no.* ext. / b. Email / c. Fax

8. Organization name* Alberta Health Services. Paroka Hosp, Jul & Care centre

9. Source of report (profession)	10. Health Canada institutional ID (If ID provided, no need to provide address)
Physician	

11. Address	12. City	13. Province / Territory	14. Postal code
5800-57 Ave. ~~Paroka~~	Paroka	AB	T4J 1P1

15. Reason for seriousness* (explain (f) in section F)

☐ (a) Death (yyyy-mm-dd) _____ ☐ (b) Life-threatening ☒ (c) Disability ☐ (d) Congenital malformation
☐ (e) Caused/prolonged in-patient hospitalization ☐ (f) Required medical intervention to avoid any of (a) to (e)

B. Patient information

1. Patient ID (e.g. initials, record no.)	2. Sex**	3. Age**	4. Height	5. Weight
[redacted]	Female	23	cm or 5 ft 2 in	kg or 157 lbs oz

6. Known medical conditions and relevant lifestyle factors* (e.g. hepatic and/or renal impairment, diabetes mellitus, current pregnancy, tobacco, cannabis or alcohol use, recreational drug use, etc.).

Endometriosis
PCOS.
Gastritis/esophagitis
Depression/anxiety.
concurrent menstruation (onset June 9/21)
Bulimia (remote Hx)
ADHD

7. Known allergies* (e.g. food, drugs, environmental, etc.; provide details).

environmental (suspected) pollen · airborne

C. Serious adverse drug reaction(s)

1. Did the patient recover?*
(please choose one of the following)

☐ Recovered ☐ Recovering ☒ Not recovered
☐ Died ☐ Unknown ☐ Recovered with sequelae

2. Reaction start date*: June 2, 2021

3. Reaction end date*: N/A

4. Description of the serious adverse drug reaction(s)**
Odynophagia. gastritis. abdominal pain

D. Suspect product one

If the DIN is not provided, please provide the brand name or the proper name, as well as the manufacturer name if known
This information is important for traceability of an adverse reaction to a specific suspect product.

1. Drug identification number (DIN)*

2. Identifying code for urgent public health need drugs**

3. Brand name** (per product label): Pfizer / BioNTech Covid 19 vaccine

4. Common/proper name** (active ingredient): COVID-19 mRNA Vaccine

5. Strength (per unit): one unit

6. Dose: 1st dose

7. Frequency: once

8. Dosage form (e.g. tablet, powder, liquid): injection

9. Route of administration: (L) deltoid, IM.

10. Product start date*: May 21, 2021

11. Product end date*

12. Indication: COVID 19 vaccination

13. Lot no.

14. Expiry date

15. a. Manufacturer name: Pfizer/ BioNTech

b. Did you also report to the manufacturer?*
☐ Yes ☒ No

c. Date reported

d. Reference no.* (if known)

16. What action was taken?: none

17. Did the reaction stop if dose was reduced or removed?
☐ Yes ☐ No ☐ Unknown ☐ N/A

18. Did the reaction return with reintroduction of the product?
☐ Yes ☐ No ☐ Unknown ☐ N/A

D. Suspect product two

If the DIN is not provided, please provide the brand name or the proper name, as well as the manufacturer name if known
This information is important for traceability of an adverse reaction to a specific suspect product.

1. Drug identification number (DIN)*	2. Identifying code for urgent public health need drugs**
3. Brand name** (per product label)	4. Common/proper name** (active ingredient)
5. Strength (per unit)	6. Dose

7. Frequency

8. Dosage form (e.g. tablet, powder, liquid)

9. Route of administration	10. Product start date*	11. Product end date*

12. Indication

13. Lot no.	14. Expiry date

15. a. Manufacturer name b. Did you also report to the manufacturer?* ☐ Yes ☐ No c. Date reported d. Reference no.* (if known)	16. What action was taken? 17. Did the reaction stop if dose was reduced or removed? ☐ Yes ☐ No ☐ Unknown ☐ N/A 18. Did the reaction return with reintroduction of the product? ☐ Yes ☐ No ☐ Unknown ☐ N/A

E. Concomitant therapeutic product(s)

1. Known therapeutic product(s) taken or used at the same time the reaction occurred* (e.g. prescription and non-prescription drugs, medical devices, natural health products, etc. Include details of use if available).

Concerta 32mg PO
Advil 200mg 2tab PO q4h PRN
Tylenol 325mg 1-2tab PO q4h PRN

F. Additional information

1. Use this section to include details that did not fit in the previous sections' structured boxes, or related test/lab results, autopsy information, treatment details, or any other details you feel would contribute to the assessment of the serious adverse drug reaction(s).

Instructions on completing the serious adverse drug reaction (ADR) reporting form for hospitals

A. General information

A1. **Initial or follow-up*:** Indicate whether the report is the first one submitted for this specific adverse drug reaction (i.e. initial) or a follow-up to a previously submitted report.

A2. **Health Canada reference number:** If the report is identified as a follow-up in A1, provide the reference number of the serious ADR report generated by Health Canada and provided to the submitter further to initial report submission.

A3. **Organization file number:** Indicate the hospital's identification number for the case. For follow-up reports, the file number should be the same as the number assigned to the initial report.

A4. **Date submitted:** Indicate the date the report was sent to Health Canada.

A5. **Documentation date*:** Indicate the date when the hospital first documented this serious ADR.

A6. **Organization contact first & last name*:** Enter the first and last name of a contact for the hospital.

A7. **Phone number, email or fax*:** Enter the telephone number, email address or facsimile number to contact in the case of follow-up.

A8. **Organization name*:** Enter the full name of the reporting hospital.

A9. **Source of report:** Indicate the profession of the hospital employee who first flagged this as a potential serious ADR.

A10. **Health Canada institutional ID:** Indicate the submitter's unique hospital identifier as assigned by Health Canada. To obtain this identifier, please contact hc.canada.vigilance.sc@canada.ca. Address details do not need to be completed if this unique number is provided.

A11. **Hospital address:** Enter the civic address for the hospital.

A12. **City:** Indicate the city in which the hospital is located.

A13. **Province/Territory:** Select the province or territory in which the hospital is located.

A14. **Postal code:** Provide the postal code of the hospital.

A15. **Reason for seriousness*:** Select a criterion that makes the report a serious adverse reaction. More than one can be selected. Enter the date of death if known.

B. Patient information

B1. **Patient ID:** Provide a patient identifier in order to readily locate the case for follow-up purposes. This can be the patient's initials or the record number. Please do not provide the full name of the patient.

B2. **Sex*†:** Enter the patient's biological sex. Intersex is a term used for a variety of conditions in which a person is born with a reproductive anatomy that does not fit the typical definitions of female or male.

B3. **Age*‡:** Provide the patient's age at the time of the reaction.

B4. **Height:** Enter the patient's height.

B5. **Weight:** Enter the patient's weight.

B6. **Known medical conditions and lifestyle factors*:** If available, provide information on the patient's history and other known conditions.

B7. **Known allergies*:** Provide the allergies the patient is known to have experienced, whether to food, drugs, environmental components, etc.

C. Serious adverse drug reaction(s)

C1. **Recovery status*:** Indicate the outcome of the serious ADR.

C2. **Reaction start date*:** Provide the date of onset of the serious ADR. Partial dates are acceptable

C3. **Reaction end date*:** Provide the end date of the serious ADR if applicable. Do not provide this for reports involving death. Partial dates are acceptable.

C4. **Description of the serious adverse drug reaction(s)*†:** List the serious adverse drug reaction(s) that the patient experienced. Please try to avoid use of acronyms in this section.

D. Suspect product(s)

Up to two suspected products may be reported on one form. Attach additional forms if there are more than two suspected products for the reported serious ADR.

Reporting of product-specific identifiers is important for traceability of an adverse reaction to a specific suspect product. The drug identification number (DIN) is a unique identifier for all drug products sold in Canada. If the DIN is unknown, biologic drugs including biosimilars can be uniquely identified by providing their brand name. Generic drugs can be uniquely identified by providing both the generic name and the manufacturer name. Please also include the lot number, if known.

D1. **Drug identification number (DIN)*:** Provide the drug identification number of the product the patient took, if available. For drugs accessed under an urgent public health need, provide the identifying code or number for the country in which the product is marketed. If the DIN is provided, it is not necessary to provide manufacturer, product name, active ingredient(s), strength, or dosage form.

D2. **Identifying code for urgent public health need drugs*†:** If the drug was imported as part of the access to drugs in exceptional circumstances, provide the code or number of the drug, if any, assigned in the country in which the drug was authorized for sale.

D3. & D4. Brand name, common/proper name*†: Provide the brand name as per the product label if the DIN is not known. If the brand name cannot be provided, or is not specific (e.g. an active ingredient as brand name), please provide the proper name (active ingredients) and the manufacturer name.

D5. **Strength:** Provide the amount of active ingredient per single dosage form of the drug. For example, if the patient took two tablets of a medication, please provide the strength of only one tablet. Strength is defined as the amount of an active ingredient that the product contains.

D6. **Dose:** Indicate the amount of the product taken by the patient per the dosing regimen. Dose is normally expressed as a quantity.

D7. **Frequency:** Indicate how often the dose was taken by the patient. Shorthand text, such as b.i.d., is acceptable in this field.

D8. **Dosage form:** Indicate the dosage form of the product (e.g. tablet, powder, liquid)

D9. **Route of administration:** Provide the means by which the drug entered the patient's body. The top five most common routes of administration are at the top of the dropdown list.

D10. **Product start date*:** Indicate the date on which the patient started using the product. If the exact date is not known, partial dates are acceptable.

D11. **Product end date*:** Indicate the date the patient stopped using the product, if applicable. Please only enter data in this field if it is known that the patient stopped taking the product. Partial dates are acceptable.

D12. **Indication:** Enter the therapeutic reason for use.

D13. **Lot no.:** If known, indicate the lot number(s) of the suspect product.

D14. **Expiry date:** If known, indicate the expiry date.

D15. **Manufacturer details*:** Indicate the manufacturer name of the suspect product and if the adverse reaction details were also provided to the manufacturer. If so, please also provide the date on which the case was reported to the manufacturer and the reference number if known.

D16. **Action taken:** Indicate what action was taken with the product.

D17. **Reaction stopped if dose was reduced or removed:** Indicate if the adverse reaction stopped after the suspect product was discontinued or the dose was reduced.

D18. **Reaction returned with reintroduction:** Indicate if the adverse reaction reappeared after the suspect product was reintroduced.

E. Concomitant therapeutic product(s)

E1. **Concomitant therapeutic products*:** List all known health products, other than the suspect product, the patient was taking at the same time (i.e. concomitantly) the reaction occurred. Information related to therapy details of these products is not required but encouraged. Do not include health products used to treat the reaction.

F. Additional information

F1. This section can be used to provide a narrative summary of the serious adverse drug reaction, additional information on the underlying diagnosis that is pertinent to the reaction, or information that did not fit in the structured fields that could help to determine why the reaction occurred. For serious cases involving death, this section can also be utilized to provide details on the official cause of death and autopsy results.

For more details, refer to the Guidance Document for hospitals at https://www.canada.ca/en/health-canada/services/drugs-health-products/medeffect-canada/adverse-reaction-reporting/mandatory-hospitalreporting/drugs-devices.html

Health Canada / Santé Canada

Serious adverse drug reaction reporting form for hospitals

Canada Vigilance - Adverse reaction reporting program

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For more information: This personal information collection is described in Info Source, available online at https://www.canada.ca/en/health-canada/corporate/about-health-canada/activities-responsibilities/access-information-privacy/info-source-federal-government-employee-information.html#a26. Refer to the personal information bank HC PPU 417.

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Fax
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Send by fax at: 1-866-678-6789

Mail it to the Canada Vigilance National Office
Canada Vigilance Program
Health Products Surveillance and Epidemiology Bureau
Marketed Health Products Directorate
Health Products and Food Branch
Health Canada
Address Locator 1908C
Ottawa, Ontario
K1A 0K9

If you have any questions related to mandatory reporting for hospitals, you may contact the Canada Vigilance Program by:
Email: hc.canada.vigilance.sc@canada.ca
Toll-free telephone: 1-866-234-2345

ENTERED

Canada

[redacted]

2 | Serious adverse drug reaction reporting form for hospitals

* = required, if known (if information is in the control of or reasonably accessible by the hospital for mandatory reporting)
** = required (hospital is exempt from mandatory reporting if this information is unavailable)
[redacted] Specific field instructions can be found at the end of the form. Submission of a report does not constitute an admission that medical personnel or the suspect product(s) caused or contributed to the serious adverse drug reaction(s).

A. General information

1. Type of report*	2. Health Canada reference no. (for follow-up reports only)
☑ Initial ☐ Follow-up	

3. Organization file no.	4. Date report submitted	5. Documentation date*
	June 23, 2021	June 22, 2021

6. a. Organization contact first name* / b. Last name*	7.a. Phone no.* / b. Email / c. Fax
	7.a. Phone no.* 4037833399 / ~~ext.~~ 4037833341 b. Email c. Fax 4037838722

8. Organization name*
Alberta Health Services - Peroka Hospital & Care Centre

9. Source of report (profession)	10. Health Canada institutional ID (If ID provided, no need to provide address)
Physician	

11. Address	12. City	13. Province / Territory	14. Postal code
5800 - 57 Avenue	Peroka	AB	T4J 1P1

15. Reason for seriousness* (explain (f) in section F)

☐ (a) Death (yyyy-mm-dd) _____ ☐ (b) Life-threatening ☑ (c) Disability ☐ (d) Congenital malformation
☐ (e) Caused/prolonged in-patient hospitalization ☐ (f) Required medical intervention to avoid any of (a) to (e)

B. Patient information

1. Patient ID (e.g. initials, record no.)	2. Sex**	3. Age**	4. Height	5. Weight
[redacted] 343768541	Male	31	175 (cm) or ft in	69 (kg) or lbs oz

6. Known medical conditions and relevant lifestyle factors* (e.g. hepatic and/or renal impairment, diabetes mellitus, current pregnancy, tobacco, cannabis or alcohol use, recreational drug use, etc.).

None

7. Known allergies* (e.g. food, drugs, environmental, etc.; provide details).

Penicillin

C. Serious adverse drug reaction(s)

1. Did the patient recover?* (please choose one of the following)
☐ Recovered ☐ Recovering ☑ Not recovered
☐ Died ☐ Unknown ☐ Recovered with sequelae

2. Reaction start date*: June 22, 2021

3. Reaction end date*: N/A

4. Description of the serious adverse drug reaction(s)**
Chest pain

D. Suspect product one

If the DIN is not provided, please provide the brand name or the proper name, as well as the manufacturer name if known. This information is important for traceability of an adverse reaction to a specific suspect product.

1. Drug identification number (DIN)*

2. Identifying code for urgent public health need drugs**

3. Brand name** (per product label): Pfizer / BioNTech COVID vaccine

4. Common/proper name** (active ingredient): COVID-19 mRNA vaccine

5. Strength (per unit): one unit

6. Dose: second injection

7. Frequency: second injection

8. Dosage form (e.g. tablet, powder, liquid): liquid

9. Route of administration: intramuscular injection, (L) deltoid

10. Product start date*: ~~June 21, 2021~~ May 13, 2021

11. Product end date*: June 21, 2021

12. Indication: COVID 19

13. Lot no.

14. Expiry date

15. a. Manufacturer name: Pfizer / BioNTech

b. Did you also report to the manufacturer?*
☐ Yes ☒ No

c. Date reported

d. Reference no.* (if known)

16. What action was taken?: N/A

17. Did the reaction stop if dose was reduced or removed?
☐ Yes ☐ No ☐ Unknown ☑ ~~N/A~~

18. Did the reaction return with reintroduction of the product?
☐ Yes ☐ No ☐ Unknown ☑ ~~N/A~~
- reaction with 2nd dose

D. Suspect product two

If the DIN is not provided, please provide the brand name or the proper name, as well as the manufacturer name if known
This information is important for traceability of an adverse reaction to a specific suspect product.

1. Drug identification number (DIN)*

2. Identifying code for urgent public health need drugs**

3. Brand name** (per product label)
Pfizer/BioNTech COVID vaccine

4. Common/proper name** (active ingredient)
COVID-19 mRNA vaccine

5. Strength (per unit)
1 unit

6. Dose
1st dose

7. Frequency
once

8. Dosage form (e.g. tablet, powder, liquid)
liquid

9. Route of administration
IM injection, deltoid

10. Product start date*
May 13/2021

11. Product end date*
N/A

12. Indication
COVID 19 vaccination

13. Lot no.

14. Expiry date

15. a. Manufacturer name
Pfizer BioNTech

b. Did you also report to the manufacturer?*
☐ Yes ☐ No

c. Date reported

d. Reference no.* (if known)

16. What action was taken?
none

17. Did the reaction stop if dose was reduced or removed?
☐ Yes ☐ No ☐ Unknown ☒ N/A

18. Did the reaction return with reintroduction of the product? (see part C.)
☐ Yes ☒ No ☐ Unknown ☐ N/A

E. Concomitant therapeutic product(s)

1. Known therapeutic product(s) taken or used at the same time the reaction occurred* (e.g. prescription and non-prescription drugs, medical devices, natural health products, etc. Include details of use if available).

None

F. Additional information

1. Use this section to include details that did not fit in the previous sections' structured boxes, or related test/lab results, autopsy information, treatment details, or any other details you feel would contribute to the assessment of the serious adverse drug reaction(s).

Instructions on completing the serious adverse drug reaction (ADR) reporting form for hospitals

A. General information

A1. **Initial or follow-up*:** Indicate whether the report is the first one submitted for this specific adverse drug reaction (i.e. initial) or a follow-up to a previously submitted report.

A2. **Health Canada reference number:** If the report is identified as a follow-up in A1, provide the reference number of the serious ADR report generated by Health Canada and provided to the submitter further to initial report submission.

A3. **Organization file number:** Indicate the hospital's identification number for the case. For follow-up reports, the file number should be the same as the number assigned to the initial report.

A4. **Date submitted:** Indicate the date the report was sent to Health Canada.

A5. **Documentation date*:** Indicate the date when the hospital first documented this serious ADR.

A6. **Organization contact first & last name*:** Enter the first and last name of a contact for the hospital.

A7. **Phone number, email or fax*:** Enter the telephone number, email address or facsimile number to contact in the case of follow-up.

A8. **Organization name*:** Enter the full name of the reporting hospital.

A9. **Source of report:** Indicate the profession of the hospital employee who first flagged this as a potential serious ADR.

A10. **Health Canada institutional ID:** Indicate the submitter's unique hospital identifier as assigned by Health Canada. To obtain this identifier, please contact hc.canada.vigilance.sc@canada.ca. Address details do not need to be completed if this unique number is provided.

A11. **Hospital address:** Enter the civic address for the hospital.

A12. **City:** Indicate the city in which the hospital is located.

A13. **Province/Territory:** Select the province or territory in which the hospital is located.

A14. **Postal code:** Provide the postal code of the hospital.

A15. **Reason for seriousness*:** Select a criterion that makes the report a serious adverse reaction. More than one can be selected. Enter the date of death if known.

B. Patient information

B1. **Patient ID:** Provide a patient identifier in order to readily locate the case for follow-up purposes. This can be the patient's initials or the record number. Please do not provide the full name of the patient.

B2. **Sex**:** Enter the patient's biological sex. Intersex is a term used for a variety of conditions in which a person is born with a reproductive anatomy that does not fit the typical definitions of female or male.

B3. **Age**:** Provide the patient's age at the time of the reaction.

B4. **Height:** Enter the patient's height.

B5. **Weight:** Enter the patient's weight.

B6. **Known medical conditions and lifestyle factors*:** If available, provide information on the patient's history and other known conditions.

B7. **Known allergies*:** Provide the allergies the patient is known to have experienced, whether to food, drugs, environmental components, etc.

C. Serious adverse drug reaction(s)

C1. **Recovery status*:** Indicate the outcome of the serious ADR.

C2. **Reaction start date*:** Provide the date of onset of the serious ADR. Partial dates are acceptable

C3. **Reaction end date*:** Provide the end date of the serious ADR if applicable. Do not provide this for reports involving death. Partial dates are acceptable.

C4. **Description of the serious adverse drug reaction(s)**:** List the serious adverse drug reaction(s) that the patient experienced. Please try to avoid use of acronyms in this section.

D. Suspect product(s)

Up to two suspected products may be reported on one form. Attach additional forms if there are more than two suspected products for the reported serious ADR.

Reporting of product-specific identifiers is important for traceability of an adverse reaction to a specific suspect product. The drug identification number (DIN) is a unique identifier for all drug products sold in Canada. If the DIN is unknown, biologic drugs including biosimilars can be uniquely identified by providing their brand name. Generic drugs can be uniquely identified by providing both the generic name and the manufacturer name. Please also include the lot number, if known.

D1. **Drug identification number (DIN)*:** Provide the drug identification number of the product the patient took, if available. For drugs accessed under an urgent public health need, provide the identifying code or number for the country in which the product is marketed. If the DIN is provided, it is not necessary to provide manufacturer, product name, active ingredient(s), strength, or dosage form.

D2. **Identifying code for urgent public health need drugs**:** If the drug was imported as part of the access to drugs in exceptional circumstances, provide the code or number of the drug, if any, assigned in the country in which the drug was authorized for sale.

D3. & D4. Brand name, common/proper name* *: Provide the brand name as per the product label if the DIN is not known. If the brand name cannot be provided, or is not specific (e.g. an active ingredient as brand name), please provide the proper name (active ingredients) and the manufacturer name.

D5. **Strength:** Provide the amount of active ingredient per single dosage form of the drug. For example, if the patient took two tablets of a medication, please provide the strength of only one tablet. Strength is defined as the amount of an active ingredient that the product contains.

D6. **Dose:** Indicate the amount of the product taken by the patient per the dosing regimen. Dose is normally expressed as a quantity.

D7. **Frequency:** Indicate how often the dose was taken by the patient. Shorthand text, such as b.i.d., is acceptable in this field.

D8. **Dosage form:** Indicate the dosage form of the product (e.g. tablet, powder, liquid)

D9. **Route of administration:** Provide the means by which the drug entered the patient's body. The top five most common routes of administration are at the top of the dropdown list.

D10. **Product start date*:** Indicate the date on which the patient started using the product. If the exact date is not known, partial dates are acceptable.

D11. **Product end date*:** Indicate the date the patient stopped using the product, if applicable. Please only enter data in this field if it is known that the patient stopped taking the product. Partial dates are acceptable.

D12. **Indication:** Enter the therapeutic reason for use.

D13. **Lot no.:** If known, indicate the lot number(s) of the suspect product.

D14. **Expiry date:** If known, indicate the expiry date.

D15. **Manufacturer details*:** Indicate the manufacturer name of the suspect product and if the adverse reaction details were also provided to the manufacturer. If so, please also provide the date on which the case was reported to the manufacturer and the reference number if known.

D16. **Action taken:** Indicate what action was taken with the product.

D17. **Reaction stopped if dose was reduced or removed:** Indicate if the adverse reaction stopped after the suspect product was discontinued or the dose was reduced.

D18. **Reaction returned with reintroduction:** Indicate if the adverse reaction reappeared after the suspect product was reintroduced.

E. Concomitant therapeutic product(s)

E1. **Concomitant therapeutic products*:** List all known health products, other than the suspect product, the patient was taking at the same time (i.e. concomitantly) the reaction occurred. Information related to therapy details of these products is not required but encouraged. Do not include health products used to treat the reaction.

F. Additional information

F1. This section can be used to provide a narrative summary of the serious adverse drug reaction, additional information on the underlying diagnosis that is pertinent to the reaction, or information that did not fit in the structured fields that could help to determine why the reaction occurred. For serious cases involving death, this section can also be utilized to provide details on the official cause of death and autopsy results.

For more details, refer to the Guidance Document for hospitals at https://www.canada.ca/en/health-canada/services/drugs-health-products/medeffect-canada/adverse-reaction-reporting/mandatory-hospitalreporting/drugs-devices.html

June 24/21

BATTLE RIVER MEDICAL CLINIC

Dr. Chan
Dr. Du Toit
Dr. Gilbert
Dr. Goosen
Dr. Greyling
Dr. Halse
Dr. Moore
Dr. Sawisk
Dr. Seavilleklein

FAXED
AUG 10 2021
Page ... of ...

Fax Cover Sheet

Date: Aug 10 21

To: Provincial AEFI Team

Fax: 780-342-0248

Phone: _____

Number of Pages including Cover: 3

[redacted]

From: Audrey per Dr. Chan

Notes: re: [redacted]

Attention: [redacted]

*Contents of this transmission are intended for the use of addressee only and may contain information that is privileged and confidential. If you are not the intended recipient, please be advised that any discussion, distribution, or copy of the content of this fax is strictly prohibited. If you receive this fax in error, or if you have difficulty receiving this fax, please notify us immediately by calling the number noted below.

Battle River Medical Clinic
Bay 2, 4502 50 Street Ponoka, Alberta, T4J 1J5
Phone: 403-783-3399 Fax: 403-783-8722

Alberta Health Services

Healthy Albertans.
Healthy Communities.
Together.

August 5, 2021

Dr. Gregory Chan
Battle River Medical Clinic
4502 50st
Ponoka, AB
T4J1J5
Fax: 403-783-8722
Phone: 403- 783-3399

Dear Dr. Chan

In accordance with the Health Information Act Sections 27(1) and 35(1), I am requesting a copy of all medical notes including any and all diagnosis related to the immunization for the following patient:

Name: [redacted]
DOB: [redacted]
PHN: [redacted]
Related immunization/immunization date: May 8 – 1st dose Pfizer vaccine

This request is made for the purpose of investigating an adverse event following immunization reported to us by this individual.

Please arrange to have the information faxed to my attention at 780-342-0248. Your assistance is appreciated.

① Need verbal consent
-given [redacted]
② If ok then send record from May 2021 to present (clinic notes)

Sincerely,

[redacted]
Provincial AEFI Team

May 28, 2021 GC

May 28, 2021, 3:30PM

Action - patient brought to room by AE

S: massage 4 days prior to Saturday
having pain in the back
better with tylenol and repositioning
spasm type of symptoms
can radiate to the neck as well
also under the left side
pressure sensation, worse when getting up
had vaccination Saturday
symptoms started Saturday
heavy feeling in left leg then resolved

O: BP 138/86
Resp clear
CVS normal
axilla normal

A: ? vaccine related MSK pain
MSK strain

P: observe for now
analgesia
advised to report side effects
considering 2nd dose August
Dr. Gregory Chan, May 28, 2021, 3:50PM

Jun 14, 2021 Ponoka HCC Lab Data GC

Accession Number	1406:B01494R			
Report Date	Jun 14, 2021 4:09PM			
Collection Date	Jun 14, 2021 3:25PM			
Specimen Received	Jun 14, 2021 3:25PM			
Ordering Physician: Chan, Gregory				
CREATININE: (Final)				
- CREATININE	57	40	- 100	umol/L
- GFR ESTIMATED	101	>59		
Reduced muscle mass will lead to overestimation, and increased muscle mass to underestimation of eGFR.				
GLUCOSE RANDOM: (Final)				
- GLUCOSE RANDOM	5.0	3.3	- 11.0	mmol/L
UREA: (Final)				
- UREA	3.7	2.0	- 7.0	mmol/L
ELECTROLYTES: (Final)				
- SODIUM	140	135	- 145	mmol/L
- POTASSIUM	3.7	3.5	- 5.0	mmol/L
- CHLORIDE	102	98	- 112	mmol/L
- CARBON DIOXIDE	28	20	- 32	mmol/L
- ANION GAP	10	4	- 14	

Jun 24, 2021 GC

Jun 24, 2021, 11:56AM

Action - patient brought to room by BR
reported to AEFI
will get testing for EMG
check urine
Dr. Gregory Chan, June 24, 2021, 12:09PM

Jul 5, 2021 GC

Dr. Gregory Chan, July 5, 2021, 4:43PM
**** COVID-19 telephone conversation ****
discussed vaccine and other therapies
longer term fever for 8 days
AEFI form done
Dr. Gregory Chan, July 5, 2021, 5:00PM

Jul 12, 2021 GC

Dr. Gregory Chan, July 12, 2021, 5:55PM
**** COVID-19 telephone conversation ****
was having some hip pain
started mid week after sleep
not immediately after a hike
? arthritis
1 month ago
3 weeks after having COVID vaccine
Pfizer, 2nd injection
bilateral, worse in the left
feels like it is in the joint
get XR and labs (routine)
AEFI sumbitted
Dr. Gregory Chan, July 12, 2021, 6:07PM

Jul 21, 2021 GC

Jul 21, 2021, 3:02PM
Action - patient brought to room by AE
Resp clear
CVS normal
echo and stress test normal

check labs again D dimer
? capillary clotting
AEFI done
Dr. Gregory Chan, July 21, 2021, 3:21PM

Jul 23, 2021 GC

Dr. Gregory Chan, July 23, 2021, 12:28PM
**** COVID-19 telephone conversation ****
taking aspirin, still short of breath
advised to take xarelto instead
will arrange for CT
Dr. Gregory Chan, July 23, 2021, 12:35PM

Aug 5, 2021 GC

Aug 5, 2021, 2:49PM
Action - patient brought to room by AE
reviewed CT scan
slight imporvement
discussed mixing of vaccines
discussed note for travel
Dr. Gregory Chan, August 5, 2021, 3:15PM

Sep 29, 2021 GC

Sep 29, 2021, 10:37AM
Action - patient brought to room by AE
would like letter
had reaction to vaccine, confirmed with consultation
advised to have pelvic ultrasound
Dr. Wynick
Neurologist next Wednesday
breathing is a little better
fatigued then difficulty sleeping
advised to talk to Northcott and write letter
BP 144/78
will try melatonin
Dr. Gregory Chan, September 29, 2021, 11:14AM

Dec 6, 2021 DP/BR

Dec 6, 2021, 11:03AM
Action - patient brought to room by BR
Pre-Op
BP: 139/83
HT: 150.5, WT: 66.9, BMI: 29.5
PRE OP - to Dr.HOCKLEY

Needs to be faxed - history as below
Reacted to her moderna. Was really tired after 1st dose. Felt like she was having a heart attack, lot of pressure. Went to hospital, did tests and said it was a reaction. Didn't get second dose. Not admitted, not diagnosed with myocarditis or endocarditis. Advised to call 811 for advice for a second dose.

GC

Jul 21, 2021

Jul 21, 2021, 3:04PM

Action - patient brought to room by AE
hand healed
fatigue +++ since vaccination
AEFI report done
2nd injection July 2/21
Dr. Gregory Chan, July 21, 2021, 3:30PM

Aug 10, 2021 GC

Aug 10, 2021, 3:57PM

Action - patient brought to room by AE
BP: 154/82 numbers at home are OK
refill medications
since second vaccine - more drained
June 16/21 - 2nd vaccine
AEFI done
fatigue ++
will cut back on medications due to good a1c and pressure normal at home
Dr. Gregory Chan, August 10, 2021, 4:21PM

Alberta Health Services

AEFI Reporting Form

Note: This form is for health care practitioner use only. If you are a member of the general public and need to report an adverse event following immunization, please call Health Link at 811 or contact your health provider.

1. Today's Date*
   8/9/2021

2. Reporter(Your) LastName*
   CHAN

3. Reporter(Your) FirstName*
   GREGORY

4. Reporter (Your) SiteType:*
   Physician

5. If Other SiteType, please specify:

6. Reporter(Your) Phone#*
   (only numbers, no -,())
   403-783-3399

7. Immunization Facility:

Name	SiteType	If other SiteType, please specify
Battle River Medical Clinic	Physician	

8. Immunization Facility Phone#
   (only numbers, no -,())
   403-783-3399

9. Immunizing Facility Address

Building No/Street/PO Box	City/Town	Province	Postalcode(A1A 1A1)
BAY2, 4502-50 STI	PONOKA	AB	T4J 1J5

10. Select Zone: (Click here to determine zone.)

Central

11. Patient LastName*

[redacted]

12. Patient FirstName*

[redacted]

13. If Patient is a minor, then Parent/Guardian

LastName	FirstName	RelationToPatient
-	-	-

14. Patient Sex at Birth:*

M-Male

15. Patient/Guardian Phone#*

(only numbers, no -,())

[redacted]

16. PHN/ULI Info:

[redacted]

17. Date Of Birth(dd/mm/yyyy)*

[redacted]

18. Patient Address:

Building No/Street/POBox	City/Town	Province	PostalCode(A1A 1A1)
[redacted]	[redacted]	[redacted]	[redacted]

19. Date Of Immunization(dd/mm/yyyy):*

    01/06/2021

20. Time of Immunization(If Known)(00:00:00)

    16:07:00

21. List all the vaccines given on date of immunization.
    Immunization Information:

Vaccine Code	Manufacturer	LotNo.
COVMODmRI	MODTH-Mod	3001945
-- Please Sel	-- Please Sel	
-- Please Sel	-- Please Sel	
-- Please Sel	-- Please Sel	
-- Please Sel	-- Please Sel	

22. Adverse Event Info:

Symptoms	Started Date (mm/dd/yyyy)	Resolved?	Resolved Date (mm/dd/yyyy)
Other	06/07/2021	No	
None		None	
None		None	
None		None	

23. If other, describe including Started date & Resolved date:

24. Additional Information:

    severe blisters on both hands recurrent, not resolving
    requiring antibiotics, and treatment in clinic/ER
    biopsy performed, results pending

25. Patient is aware that you are reporting the AEFI description and patient contact information to Alberta Health Services AEFI follow-up.*

    Yes

26. Patient is aware Alberta Health services AEFI program may be contacting them.*

    Yes

Note:Hit Done button to Submit the Form.

Alberta Health Services (AHS) respects your confidentiality and privacy. Your information is collected, used, disclosed and protected according to the provisions of provincial and federal legislation. Your health information is collected by AHS in accordance with section 20 of the Health Information Act (HIA). The purpose of this collection is primarily for: providing health services, determining eligibility for health services, processing payments for health services, conducting research, providing for health services, provider education, internal management purposes, planning and resource allocation, health system management, public health surveillance and health policy development.

Done

Alberta Health Services

AEFI Reporting Form

Note: This form is for health care practitioner use only. If you are a member of the general public and need to report an adverse event following immunization, please call Health Link at 811 or contact your health provider.

1. Today's Date*
   23/9/2021

2. Reporter(Your) LastName*
   CHAN

3. Reporter(Your) FirstName*
   GREGORY

4. Reporter (Your) SiteType:*
   Physician

5. If Other SiteType, please specify:

6. Reporter(Your) Phone#*
   (only numbers, no -,())
   403-783-3399

7. Immunization Facility:

Name	SiteType	If other SiteType, please specify
CCMHBI	AHS Acute Care	

8. Immunization Facility Phone#
   (only numbers, no -,())
   403-783-7600

9. Immunizing Facility Address

Building No/Street/PO Box	City/Town	Province	Postalcode(A1A 1A1)

-	PONOKA	AB

10. Select Zone: (Click here to determine zone.)
    Central

11. Patient LastName*
    [redacted]

12. Patient FirstName*
    [redacted]

13. If Patient is a minor, then Parent/Guardian

LastName	FirstName	RelationToPatient
-	-	-

14. Patient Sex at Birth:*
    M-Male

15. Patient/Guardian Phone#*
    (only numbers, no -,())
    [redacted]

16. PHN/ULI Info:
    [redacted]

17. Date Of Birth(dd/mm/yyyy)*
    [redacted]

18. Patient Address:

Building No/Street/POBox	City/Town	Province	PostalCode(A1A 1A1)
[redacted]	[redacted]	[redacted]	[redacted]

19. Date Of Immunization(dd/mm/yyyy):*
    09/09/2021

20. Time of Immunization(If Known)(00:00:00)
    00:00:00

21. List all the vaccines given on date of immunization.
    Immunization Information:

Vaccine Code	Manufacturer	LotNo.
COVPBmR	BPF-BioNT	
-- Please S	-- Please S	

-- Please S ✓ -- Please S ✓

-- Please S ✓ -- Please S ✓

-- Please S ✓ -- Please S ✓

22. Adverse Event Info:

Symptoms	Started Date (mm/dd/yyyy)	Resolved?	Resolved Date (mm/dd/yyyy)
Other ✓	09/09/2021	No ✓	
None ✓		None ✓	
None ✓		None ✓	
None ✓		None ✓	

23. If other, describe including Started date & Resolved date:

severe fatigue

24. Additional Information:

was an inpatient at the CCMHBI, received 1st dose of PFIZER and became fatigued
drowsy all day, difficulty staying awake
medications have not changed before and after the vaccine (the only difference was receiving the PFIZER injection)

25. Patient is aware that you are reporting the AEFI description and patient contact information to Alberta Health Services AEFI follow-up.*

Yes ✓

26. Patient is aware Alberta Health services AEFI program may be contacting them.*

Yes ✓

Note:Hit Done button to Submit the Form.

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Done

Alberta Health Services

AEFI Reporting Form

[redacted]

Note: This form is for health care practitioner use only. If you are a member of the general public and need to report an adverse event following immunization, please call Health Link at 811 or contact your health provider.

1. Today's Date*
   4/10/2021

2. Reporter(Your) LastName*
   CHAN

3. Reporter(Your) FirstName*
   GREGORY

4. Reporter (Your) SiteType:*
   Physician

5. If Other SiteType, please specify:

6. Reporter(Your) Phone#*
   (only numbers, no -,())
   403-783-3399

7. Immunization Facility:

Name	SiteType	If other SiteType, please specify
IDA Pharmacy	Pharmacy	

8. Immunization Facility Phone#
   (only numbers, no -,())
   403-790-1970

9. Immunizing Facility Address

Building No/Street/PO Box	City/Town	Province	Postalcode(A1A 1A1)

5020 50 ST PONOKA AB T4J 1S3

10. Select Zone: (Click here to determine zone.)
    Central

11. Patient LastName*
    [redacted]

12. Patient FirstName*
    [redacted]

13. If Patient is a minor, then Parent/Guardian

LastName	FirstName	RelationToPatient
-	-	-

14. Patient Sex at Birth:*
    F-Female

15. Patient/Guardian Phone#*
    (only numbers, no -,())
    [redacted]

16. PHN/ULI Info:
    [redacted]

17. Date Of Birth(dd/mm/yyyy)*
    [redacted]

18. Patient Address:

Building No/Street/POBox	City/Town	Province	PostalCode(A1A 1A1)
[redacted]	[redacted]	[redacted]	[redacted]

19. Date Of Immunization(dd/mm/yyyy):*
    16/08/2021

20. Time of Immunization(If Known)(00:00:00)
    00:00:00

21. List all the vaccines given on date of immunization.
    Immunization Information:

Vaccine Code	Manufacturer	LotNo.
COVPBmR	BPF-BioNT	
-- Please S	-- Please S	

-- Please S ▾ -- Please S ▾

-- Please S ▾ -- Please S ▾

-- Please S ▾ -- Please S ▾

22. Adverse Event Info:

Symptoms	Started Date (mm/dd/yyyy)	Resolved?	Resolved Date (mm/dd/yyyy)
Other ▾	08/23/2021	No ▾	
None ▾		None ▾	
None ▾		None ▾	
None ▾		None ▾	

23. If other, describe including Started date & Resolved date:

chest pain, dyspnea

24. Additional Information:

1 week after 2nd injection, occurring about 1-2 times a week, not present previously. mild dyspnea. Chest pain

25. Patient is aware that you are reporting the AEFI description and patient contact information to Alberta Health Services AEFI follow-up.*

Yes ▾

26. Patient is aware Alberta Health services AEFI program may be contacting them.*

Yes ▾

Note:Hit Done button to Submit the Form.

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Done

Alberta Health Services

AEFI Reporting Form

Note: This form is for health care practitioner use only. If you are a member of the general public and need to report an adverse event following immunization, please call Health Link at 811 or contact your health provider.

1. Today's Date*
   8/10/2021

2. Reporter(Your) LastName*
   CHAN

3. Reporter(Your) FirstName*
   GREGORY

4. Reporter (Your) SiteType:*
   Physician

5. If Other SiteType, please specify:

6. Reporter(Your) Phone#*
   (only numbers, no -,())
   403-783-3399

7. Immunization Facility:

Name	SiteType	If other SiteType, please specify
Rexall	Pharmacy	

8. Immunization Facility Phone#
   (only numbers, no -,())
   403-783-5568

9. Immunizing Facility Address

Building No/Street/PO Box	City/Town	Province	Postalcode(A1A 1A1)

4502-50 STREE PONOKA AB T4J 1J5

10. Select Zone: (Click here to determine zone.)
    Central

11. Patient LastName*
    [redacted]

12. Patient FirstName*
    [redacted]

13. If Patient is a minor, then Parent/Guardian

LastName	FirstName	RelationToPatient
-	-	-

14. Patient Sex at Birth:*
    F-Female

15. Patient/Guardian Phone#*
    (only numbers, no -,())
    [redacted]

16. PHN/ULI Info:
    [redacted]

17. Date Of Birth(dd/mm/yyyy)*
    [redacted]

18. Patient Address:

Building No/Street/POBox	City/Town	Province	PostalCode(A1A 1A1)
[redacted]	[redacted]	[redacted]	[redacted]

19. Date Of Immunization(dd/mm/yyyy):*
    22/09/2021

20. Time of Immunization(If Known)(00:00:00)
    00:00:00

21. List all the vaccines given on date of immunization.
    Immunization Information:

Vaccine Code	Manufacturer	LotNo.
COVPBmR	BPF-BioNT	
-- Please S	-- Please S	

-- Please S ▾ -- Please S ▾

-- Please S ▾ -- Please S ▾

-- Please S ▾ -- Please S ▾

22. Adverse Event Info:

Symptoms	Started Date (mm/dd/yyyy)	Resolved?	Resolved Date (mm/dd/yyyy)
Fever ▾	09/22/2021	No ▾	
Other ▾	09/22/2021	No ▾	
None ▾		None ▾	
None ▾		None ▾	

23. If other, describe including Started date & Resolved date:

sore throat chest pain dyspnea since injection

24. Additional Information:

patient has had COVID in Dec 2020, and the day of and day 1 post injection she had chest pain, shortness of breath, fever, sore throat. General malaise. The fever persists (intermittently), and has ongoing sore throat, chest pain and headaches +++

25. Patient is aware that you are reporting the AEFI description and patient contact information to Alberta Health Services AEFI follow-up.*

Yes ▾

26. Patient is aware Alberta Health services AEFI program may be contacting them.*

Yes ▾

Note:Hit Done button to Submit the Form.

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Done

Dec 7, 2021

AE

Call from [redacted] AHS-780-702-2653 for Dr Chan
advised away and would get message upon return
AFI CDC recommendations on report given by you
No contraindications to vaccine and future doses
message printed for Dr Chan upon return
MOA:Audrey Epp, Dec 7, 2021, 4:23PM

Alberta Health Services

AEFI Reporting Form

Note: This form is for health care practitioner use only. If you are a member of the general public and need to report an adverse event following immunization, please call Health Link at 811 or contact your health provider.

1. Today's Date*
   12/10/2021
2. Reporter(Your) LastName*
   CHAN
3. Reporter(Your) FirstName*
   GREGORY
4. Reporter (Your) SiteType: *
   Physician
5. If Other SiteType, please specify:
6. Reporter(Your) Phone#*
   (only numbers, no -,())
   403-783-3399
7. Immunization Facility:

Name	SiteType	If other SiteType, please specify
Shoppers Drug Mart	Pharmacy	

8. Immunization Facility Phone#
   (only numbers, no -,())
   403-783-3248
9. Immunizing Facility Address

Building No/Street/PO Box	City/Town	Province	Postalcode(A1A 1A1)
5015-50 STREET	PONOKA	AB	T4J 0C1

10. Select Zone: (Click here to determine zone.)
    Central
11. Patient LastName*
    [redacted]
12. Patient FirstName*
    [redacted]
13. If Patient is a minor, then Parent/Guardian

LastName	FirstName	RelationToPatient

14. Patient Sex at Birth: *
    M-Male
15. Patient/Guardian Phone#*
    (only numbers, no -,())
    [redacted]
16. PHN/ULI Info:
    [redacted]
17. Date Of Birth(dd/mm/yyyy)*
    [redacted]
18. Patient Address:

Building No/Street/POBox	City/Town	Province	PostalCode(A1A 1A1)
[redacted]	[redacted]	[redacted]	[redacted]

19. Date Of Immunization(dd/mm/yyyy):*
    22/09/2021
20. Time of Immunization(If Known)(00:00:00)
    00:00:00
21. List all the vaccines given on date of immunization.
    Immunization Information:

Vaccine Code	Manufacturer	LotNo.
COVPfizmRNA	BPF-BioNTec	
-- Please Sel	-- Please Sel	
-- Please Sel	-- Please Sel	
-- Please Sel	-- Please Sel	
-- Please Sel	-- Please Sel	

22. Adverse Event Info:

Symptoms	Started Date (mm/dd/yyyy)	Resolved?	Resolved Date (mm/dd/yyyy)
Other	09/29/2021	No	
None		None	
None		None	
None		None	

23. If other, describe including Started date & Resolved date:
    chest pain, heaviness, intermittent
24. Additional Information:
    5 days after immunization with SECOND dose of PFIZER COVID vaccine, then having chest heaviness like someone is sitting on his chest
    Tolweryl, ECG, echo pending
25. Patient is aware that you are reporting the AEFI description and patient contact information to Alberta Health Services AEFI follow-up.*
    Yes
26. Patient is aware Alberta Health services AEFI program may be contacting them. *
    Yes

Note: Hit Done button to Submit the Form.

Alberta Health Services (AHS) respects your confidentiality and privacy. Your information is collected, used, disclosed and protected according to the provisions of provincial and federal legislation. Your health information is collected by AHS in accordance with section 20 of the Health Information Act (HIA). The purpose of this collection is primarily for: providing health services, determining eligibility for health services, processing payments for health services, conducting research, providing for health services, provider education, internal management purposes, planning and resource allocation, health system management, public health surveillance and health policy development.

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