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*
   13/10/2021

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 -,())

7. Immunization Facility:

Name	SiteType	If other SiteType, please specify
East Central Health/Camrose	Public Health	

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

9. Immunizing Facility Address

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

5510 46 AVE CAMROSE AB T4V 4P8

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

    Central

11. Patient LastName*

    DE VRIES

12. Patient FirstName*

    MATTY

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 -,())

    403-505-0332

16. PHN/ULI Info:

    287638590

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

    06/10/1989

18. Patient Address:

Building No/Street/POBox	City/Town	Province	PostalCode(A1A 1A1)
RR4	DONALDA	AB	T0B 1H0

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

    12/07/2021

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	09/11/2021	No	
None		None	
None		None	
None		None	

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

fetal demise

24. Additional Information:

patient is a G4 P3 @ 25+5wk. Last ultrasound Sept 10/21 - normal. 1st injection was May 20/21 and second injection Jul 12/21 for COVID Pfizer/BioNTech. Based on today's ultrasound, minimal growth from Sept 10/21 US. Fetal demise. I have not informed the patient about AEFI contacting them because they are now in Unit 27 Red Deer for consultation with OBGYN.

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

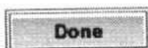
No

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

No

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.



Alberta Health Services

AEFI Reporting Form

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1. Today's Date*
   19/10/2021
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 -,())
7. Immunization Facility:

Name	SiteType	If other SiteType, please specify
Ponoka Professional Pharma	Pharmacy	

8. Immunization Facility Phone#
   (only numbers, no -,())
   403-783-7333
9. Immunizing Facility Address

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

BAY 20, 5011-48 PONOKA AB T4J 1J3

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
[redacted]	[redacted]	Mother

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):*

    06/10/2021

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.
COVMODm ⌄	MODTH-Mc ⌄	
-- Please Se ⌄	-- Please Se ⌄	

-- 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)
Rash	10/06/2021	No	
Other	10/16/2021	Yes	10/18/2021
None		None	
None		None	

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

tested positive for COVID

24. Additional Information:

OTHER reaction - had 1st injection of MODERNA Oct 6/21
prevalence testing due to 'outbreak' at school - tested positive with RAPID test @ Shoppers Drug Mart Oct 13/21. Symptoms of COVID onset Oct 16/21 - sore throat runny nose. Resolved as of Oct 18/21.
RASH - immediate red raised rash at injection site, resolved with oral antihistamines but has recurred today October 19, 2021.

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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Nov 9, 2021 Letter GC

Needs Printing

To: Dr. [redacted] Phone: [redacted] Fax: [redacted] Faxed: Wed, Nov 10, 2021

Dear Dr. [redacted]

Re: [redacted] [redacted] Age: 52 yr HN: [redacted]
Address: [redacted]
Phone: [redacted] Mobile: Business:

Thank you for reviewing this case. I would respectfully ask that this patient's Adverse Event Following Immunization be considered as related to COVID-19 vaccination. He received his first dose of the vaccine September 10. He describes an illness progression that started Sep 11/21 and was slowly progressive until his first presentation to Ponoka ER/OPD October 8/21. He was treated and sent home but the symptoms continued to progress such that he had to be admitted to hospital October 20/21.

As we do not have clear long-term data on the adverse events following COVID-19 immunization, I would suggest collecting all possible events as 'related to COVID vaccination'. Once all signals are collected, then rare events could be discarded. This process would take years to collect and process, and should not be filtered out at the point of entry

Nov 10, 2021 GC/PS

Office of [redacted] called
letter was received and they require forms to be filled out
printed and given to Dr Chan
Panel Manager: [redacted] Nov 10, 2021, 3:48PM

discussed with [redacted] with elevated WBC
Dr. Gregory Chan, November 10, 2021, 4:05PM

This document contains personal identifiable information that must be treated confidentially. Any unauthorized use or disclosure is prohibited.

Alberta Health Services

AEFI Reporting Form

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1. Today's Date*
   21/10/2021

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
	unknown	Pharmacy	

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

9. Immunizing Facility Address

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

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

11. Patient LastName*

12. Patient FirstName*

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

LastName	FirstName	RelationToPatient
-		

14. Patient Sex at Birth: *

-- Please Select --

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): *

10/09/2021

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.
COVPBmRN	BPF-BioNTe	
-- 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	09/10/2021	No	
Other	09/30/2021	No	
None		None	
None		None	

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

Malaise, cough, night sweats. Leukocytosis.

24. Additional Information:

This patient was immunized for COVID on Sep 10/21. He felt unwell, a heaviness in his chest after immunization (Sep 10 or a few days after according to the patient), was asymptomatic prior to immunization.
[redacted] examined at the ER when the symptoms did not resolve Oct 8/21. Had elevated WBC (13) and neutrophil count (9.5). ECG normal. Diagnosed with anxiety and discharged. These symptoms have not resolved completely, and progressed (see below).
Progressive symptoms for 3 weeks (onset Sept 30/21)- night sweats, malaise, weakness, cough.
Presented to hospital Oct 20/21 with fever and cough. Chest x-ray normal. WBC 33.2 and Neutrophil 31.9. Low lymphocyte count 0.7. Slight elevation of D-dimer 0.12, 0.15. CRP 49, 116. Blood cultures drawn. COVID PCR testing negative (ID NOW and RAPID NAT)

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*
   22/10/2021

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
Ponoka Professional Pharma	Pharmacy	

8. Immunization Facility Phone#
   (only numbers, no -,())
   403-783-7333

9. Immunizing Facility Address

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

20-5011 48 AVE	PONOKA	AB	T4J 1J3

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):*
    06/10/2021

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.
COVMODm	MODTH-Mc	
-- 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	10/08/2021	No	
Other	10/20/2021	No	
Other	10/20/2021	No	
None		None	

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

fatigue, COVID, thrombocytopenia

24. Additional Information:

```
Vaccine #1 for COVID Oct 6/21. Felt unwell with dizziness Oct 9/21. Positive family contact
for COVID (children at school were close contacts), so [redacted] went for testing on Oct
13/21 and had RAPID test in Shoppers Pharmacy and negative. Symptoms continued to persist
and worsen thereafter.
Oct 20/21 phone appt and then sent to Hospital due to severe fatigue. Positive RAPID test
at hospital.
Also had thrombocytopenia on labwork.
```

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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Dec 21, 2021 GC

Dr. Gregory Chan, December 21, 2021, 3:10PM - discussed with [redacted] from AEFI
answered questions about Raynaud's, auto immune condition
pt had Pfizer injection (booster)
Dr. Gregory Chan, December 21, 2021, 3:17PM

Dec 29, 2021 GC/PS

[redacted] from AEFI
reported even to AHS
can continue with vaccinations for Covid and MRNA
note to Dr Chan
Panel Manager: Penny Skjonsberg, Dec 29, 2021, 11:21AM

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Alberta Health Services

AEFI Reporting Form

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1. Today's Date*
   29/10/2021

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 -,())

7. Immunization Facility:

Name	SiteType	If other SiteType, please specify
Shopper's Drug Mart	Pharmacy	

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

9. Immunizing Facility Address

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

5015 50TH STRE PONOKA ALBERTA 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):*

    02/06/2021

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.
COVAUVec	AZC-AstraZ	
-- 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	06/16/2021	No	
None		None	
None		None	
None		None	

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

severe colour and temperature change in fingers

24. Additional Information:

```
multiple fingers and toes will change colour from normal (pink) to white, sometimes painful
definite change in temperature sensation (cold)
previously would occur in only cold temperatures
now occurs in situations irrespective of external/ambient temperature
```

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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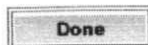

![Alberta Health Services]

Alberta Health Services

AEFI Reporting Form

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1. Today's Date*
   2/11/2021

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 -,())

7. Immunization Facility:

Name	SiteType	If other SiteType, please specify
Unknown	-- Please Select --	

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

9. Immunizing Facility Address

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

-	-	-

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):*

    04/10/2021

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	10/30/2021	No	
None		None	
None		None	
None		None	

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

Chest pain

24. Additional Information:

```
immunization at RIMOKA LODGE Oct 4/21 - 3rd injection of PFIZER for COVID
had right sided chest pain and presented to ER Oct 31/21
sent home and came back by ambulance with chest pain. Vitals normal
D-dimer positive at 1.17. CT chest for PE protocol was negative for large PE
sent home with XARELTO to treat suspected microclotting
```

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

No

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

No

Note:Hit Done button to Submit the Form.

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Done

![Alberta Health Services]

Alberta Health Services

AEFI Reporting Form

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1. Today's Date*
   2/11/2021

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 -,())

7. Immunization Facility:*

Name	SiteType	If other SiteType, please specify
Unknown	Pharmacy	

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

9. Immunizing Facility Address

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

-	-	-

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):*

    04/10/2021

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	11/01/2021	Yes	11/01/2021
None		None	
None		None	
None		None	

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

dizziness, felt like lights closing in

24. Additional Information:

```
had 3rd booster for COVID Oct 4/21, given at her lodge by ? pharmacy (as per netcare)
had sudden dizziness, nearly fell
came to ER to be checked - had elevated BP >220/90, subsequent BP was 190/100
tests done - positive D-dimer 0.89
dizziness resolved, went home
```

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

No

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

No

Note:Hit Done button to Submit the Form.

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Dec 23, 2021

PS

As per Phone call from AHS
No contra-indications for future covid vaccinations
Dr Chan has been made aware
Panel Manager: Dec 23, 2021, 9:09AM

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Alberta Health Services

AEFI Reporting Form

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1. Today's Date*

   2/11/2021

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 -,())

7. Immunization Facility:

Name	SiteType	If other SiteType, please specify
Shopper's Drug Mart	Pharmacy	

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

9. Immunizing Facility Address

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

5015 50TH STRE	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:*
    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):*
    28/06/2021

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 Se	-- Please Se
-- Please Se	-- Please Se
-- Please Se	-- Please Se

22. Adverse Event Info:

Symptoms	Started Date (mm/dd/yyyy)	Resolved?	Resolved Date (mm/dd/yyyy)
Other	09/02/2021	No	
None		None	
None		None	
None		None	

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

Change in menstruation

24. Additional Information:

Patient had her second dose of PFIZER COVID immunization June 28/21. Menstruation in September was lighter and shorter. Now NO MENSES in October.
Patient is on oral contraceptives and has had 2 negative home pregnancy tests

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.

Jan 17, 2022 GC/PS

AHS-[redacted]
AEFI request for medical records
sent to 1-780-342-0248
verbal consent given
Panel Manager: [redacted] Jan 17, 2022, 9:40AM

Jan 17, 2022 GC/PS

[redacted] from Adverse Events
to confirm that rash was or was not related to vaccine
As per Dr Chan was not
as per [redacted] there is no contradiction and can have further doses in the future
Panel Manager: [redacted] Jan 17, 2022, 11:40AM

This document contains personal identifiable information that must be treated confidentially. Any unauthorized use or disclosure is prohibited.

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*
   5/11/2021

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 -,())

7. Immunization Facility:

Name	SiteType	If other SiteType, please specify
Ponoka Professional Pharma	Pharmacy	

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

9. Immunizing Facility Address

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

5011-48 AVE	PONOKA	AB	T4J 1R5

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):*

    19/10/2021

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.
COVMODm	MODTH-Mc	
-- 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	10/22/2021	Yes	10/29/2021
Severe Diarrhe	10/22/2021	Yes	10/29/2021
None		None	
None		None	

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

24. Additional Information:

1st dose of MODERNA
diarrhea FRIDAY to Sunday morning, dizziness, fever
1 week of symptoms until completely resolved

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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Alberta Health Services

AEFI Reporting Form

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1. Today's Date*
   9/11/2021
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 - 50TH ST PONOKA ALBERTA 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):*
    22/10/2021

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	30/10/2021	No	
None		None	
None		None	
None		None	

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

lesion on tongue

24. Additional Information:

new lesion on tongue, onset at the end of the month
leukoplakia at mid-posterior tongue (adjacent to most posterior left molar), with a 3-4mm area of brown hardening anterior to the leukoplakia
referral to ENT for assessment

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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Dec 2, 2021 GC/PS

call from [redacted]-AHS- 780-702-2653
Investigation into affects after covid vaccine

reportable rash
recommendation was to receive further doses of the vaccine

she is aware of this recommendation from AHS

Dr given note to review and [redacted] said can call if he has questions

Panel Manager: [redacted] Dec 2, 2021, 2:59PM

This document contains personal identifiable information that must be treated confidentially. Any unauthorized use or disclosure is prohibited.

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*
   15/11/2021

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
Safeway	Pharmacy	

8. Immunization Facility Phone#
   (only numbers, no -,())
   403-217-8527

9. Immunizing Facility Address

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

375 ASPEN GLE CALGARY ALBERTA T3H 0N6

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

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):*
    20/09/2021

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)
Rash	09/23/2021	No	
Pain and/or Sw	09/20/2021	No	
None		None	
None		None	

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

Psoriasis

24. Additional Information:

```
previously, psoriasis was well controlled
three days after 1st injection of PFIZER COVID vaccine - worsening of psoriasis in scalp,
eyes, neck
also new rash that has not resolved
also left arm pain that hurts with use of the shoulder, and touching the deltoid muscle
```

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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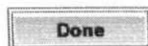

Alberta Health Services

SCANNED

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*

   12/11/2021

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 -,())

7. Immunization Facility:

Name	SiteType	If other SiteType, please specify
Ponoka Professional Pharma	Pharmacy	

8. Immunization Facility Phone#

   (only numbers, no -,())

9. Immunizing Facility Address

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

5011-48 AVE	PONOKA	AB	T4J 1R5

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):*
    07/10/2021

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.
COVPBmRN	BPF-BioNTec	
Influenza (Ag	Unknown/Otl	

-- 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	11/11/2021	No	
None		None	
None		None	
None		None	

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

diplopia

24. Additional Information:

tying shoes evening of Nov 11/21, bending over then sudden dizziness and double vision
not resolving with rest
presented to ER today at Nov 12/21 ~0900h
Hypertension - BP >200/100, normal physical and neuro exam except for DIPLOPLIA
labwork pending, awaiting CT head and neurological consultation

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

SCANNED

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*

   12/11/2021

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 -,())

7. Immunization Facility:

Name	SiteType	If other SiteType, please specify
IDA Ponoka	Pharmacy	

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

9. Immunizing Facility Address

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

5020 50 ST, PON | 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):*
10/11/2021

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.
COVPBmRN	BPF-BioNTe	
-- 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)
Pain and/or Swe	11/11/2021	No	
None		None	
None		None	
None		None	

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

Abdominal pain

24. Additional Information:

```
abdominal pain after 2nd dose of PFIZER (1st dose Oct 12/21)
right sided and central abdominal pain
investigations - fecal loading on XR, ALT 506, ALP 319, CRP 28, HB 165
previous LFTs - Aug 19/21 - ALT 20, ALP 270
US pending, plan for weekly LFTs
```

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