SCANNED

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 -,())

7. Immunization Facility:

Name	SiteType	If other SiteType, please specify
Maskwacis Health Services	Public Health	

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

9. Immunizing Facility Address

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

MINDE AVE & W | MASKWACIS | AB | T0C 1N0

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):*

21/10/2021

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.
COVMODmF	MODTH-Moc	
Influenza (Ac	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	14/11/2021	No	
None		None	
None		None	
None		None	

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

Tinnitus

24. Additional Information:

new onset of RIGHT ear tinnitus this evening at ~2100h
no recent trauma or injury or fall or loud noise/music
normal vital signs
RIGHT tympanic membrane is normal, LEFT TM normal, throat normal

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

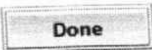
Yes

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.



Alberta Health Services

AEFI Reporting Form

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1. Today's Date*
   18/11/2021

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	-- Please Select --	

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):*
    30/09/2021

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.
COVMODm	MODTH-Mo	
-- 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)
Other	10/09/2021	No	
None		None	
None		None	
None		None	

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

dyspnea

24. Additional Information:

possibly had COVID in September, then 1st injection of Moderna Sep 30/21
persistent dyspnea, positive D-dimer, other tests negative
awaiting cardiologist and lung function tests; stress testing done

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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Jan 11, 2022 PS

Signe from AEFI-587-779-9556
Looking to speak to CG regarding symptoms
? is chest pain related to accident or vaccination
?did the pain only appeared after vaccination
?is this a previous condition
?do you think she can have further doses
She has already had two doses so not time sensitive
She Will get notes from PGH health records regarding visit on NOv 9/2021 , saw Dr Joe VanDerWesthuizen
Would like to take a quick minute so that the file can be closed
Thurs or Fri between 8:45-3:30
Note to Dr CG to review
Panel Manager: Penny Skjonsberg, Jan 11, 2022, 9:50AM

Jan 19, 2022 PS

Sigfried from AEFI called
587-779-9556
wanting to speak to Dr CG about reaction after vaccine
Advised a fax with questions and concerns should be sent
she is working from home so can not do that at this time

Says bike accident in 2020 and presented to emerg on NOv 19/2021 and saw Dr Joe Van Der Westhuizen
had cardiac tests done and were normal
was diagnosed then with Pietze Syndrome

Wants to know:
do you think her symptoms were related to the vaccine?
do you think it is a Pre Existing condition?
Is this muscle skeletal or cardiac?
Had muscular Skelatal between ribs when she had the bike accident.
Do you agree with the diagnosis of Tietze Syndrom from Dr Joe in emerg?
Any plans to do more cardiac appt/testing in the near future?

Only the dr or a nurse can call her back and relay the answers to these questions.

Note given to Dr CG to review
Panel Manager: Penny Skjonsberg, Jan 19, 2022, 10:10AM

Feb 7, 2022 PS

Signe AEFI called
587-779-9556
Wanting to close the file on this pt
If a nurse can call her back with the questions as listed about from previous calls
Panel Manager: Penny Skjonsberg, Feb 7, 2022, 1:51PM

Feb 8, 2022 GC/PS

Signe AEFI
wanting to close file
would like an appt to discuss, she said has a few questions to finish up

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

took the call
they decided to make her an appt to discuss
Mar 3/2022 for a call
Panel Manager: , Feb 8, 2022, 12:01PM

Feb 8, 2022 KS

AEFI called regarding multiple attempts to contact Dr. regarding patient history.
Asked Penny to make an appointment for Dr. to call the morning of March 3rd 2022.

Feb 8, 2022 GC/PS

587-779-9556
AEFI
booked an appt to speak to GC regarding patient as he did the AEFI form
same questions as she will be asking CG on her phone appt Mar 3/2022

Wants to know:
do you think her symptoms were related to the vaccine?
do you think it is a Pre Existing condition?
Is this muscle skeletal or cardiac?
Had muscular Skelatal between ribs when she had the bike accident.
Do you agree with the diagnosis of Tietze Syndrom from Dr in emerg?
Any plans to do more cardiac appt/testing in the near future?

Panel Manager: , Feb 8, 2022, 2:58PM

Feb 9, 2022 GC

Dr. Gregory Chan, February 9, 2022, 10:24AM
**** COVID-19 telephone conversation ****
discussed with AEFI team
they want to speak with Dr. Gilbert - I informed them that Dr. Gilbert does not want to speak with them
asking if chest pain was pre-existing -> chart review, chest pain mentioned in Aug 2020 and none since
wondering if it is a rib out
asking whether I recommend another dose - I cannot make this recommendation
advised that echo and MRI are not helpful now
Dr. Gregory Chan, February 9, 2022, 10:34AM

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Alberta Health Services

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1. Today's Date*
   18/11/2021

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 Ponoka	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):*
    21/10/2021

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)
Pain and/or Sw	10/27/2021	No	
None		None	
None		None	
None		None	

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

chest pain

24. Additional Information:

```
chest pain since SECOND dose of PFIZER Oct 21/21
HR increased from baseline
intermittent chest pain, paroxysmal
slight increase in WBC
```

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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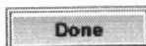

Jan 7, 2022 GC/PS

[redacted] from AHS -Adverse reaction to vaccine
587-943-1987
would like to speak to Dr Chan regarding the plan for her and also another symptom that was not written on form that she mentioned when AHS called her
note to Dr Chan to call her
Panel Manager: [redacted], Jan 7, 2022, 12:54PM

discussed with [redacted], agreed that itching is an adverse reaction, will be reported to MOH
Dr. Gregory Chan, January 7, 2022, 1:59PM

Jan 10, 2022 PS

[redacted] from AHS
discussed reaction and recommendations with Dr Horne
Pt is ok to have additional covid vaccine, recommended 30 min required after shot for viewing
note to Dr Chan to advise
Panel Manager: [redacted], Jan 10, 2022, 1:08PM

Jan 28, 2022 GC/BR

Jan 28, 2022, 9:46AM
Action - patient brought to room by BR
S: left ear infection

O: HEENT TMs left TM swollen, right normal throat normal

A: OM

P: inflammation of TM
AEFI panel has stated that benefits of booster outweigh risk of COVID
Dr. Gregory Chan, January 28, 2022, 10:11AM

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1. Today's Date*

   19/11/2021

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 Ponoka	Pharmacy	

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

9. Immunizing Facility Address

Building No/Street/PO Box	City/Town	Province	Postalcode(A1A 1A1)
BAY 3, 4502-50 ST	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):*

28/05/2021

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.
COVPBmRNA	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	05/28/2021	No	
None		None	
None		None	
None		None	

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

Pruritis

24. Additional Information:

1st injection May 28/21 - had itching immediately afterward, rapid HR, severe, called 811 and then advised to call 911
treated on site by EMS
told to take Benadryl before the 2nd dose (as per paramedics) - physician in Red Deer giving cortisone injections also suggested this
2nd injection July 7/21 - had itching worsened and flushing immediately afterwards, was given an injection of Benadryl at the pharmacy
itching persists today, worse in warm environments

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

GC/PS

Jan 21, 2022

[redacted] from AHS-780-306-2178
AEFI
wanting an appt or call to discuss
?how do you want to proceed
? doesn't know if he qualifies for an exemption
?what do you want from them
?referred to a cardiologist
Advised to fax
she said they have done that and all info has been sent
wondering about holter monitor, not on netcare
wanted to speak to him directly
advised an appt would be best
she said that was fine , advised a week + away
she said no to far
note to Dr Chan to advise
Panel Manager: [redacted] Jan 21, 2022, 2:43PM

GC

Jan 28, 2022

discussed with [redacted] regarding event
states that mom thought he was still limited between COVID and vaccine
I recall that he was able to participate in sports, but then after the vaccine he was severely limited
recently able to continue with physical activity
Dr. Gregory Chan, January 28, 2022, 5:13PM

GC

Jan 31, 2022

Jan 31, 2022, 9:52AM
Action - patient brought to room by AE
lost appetite and some fatigue from COVID infection
lost about 20lb
had some issues with stamina
was able to return to practice and workouts and dry run training
was coming back to usual self
collateral history - mom states that
then had injection then had the incident and then amnesia of the event
fatigued, pale and took weeks to recover

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Alberta Health Services

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1. Today's Date*
   25/11/2021

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
Save-On-Foods Trinity Hills	Pharmacy	

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

9. Immunizing Facility Address

Building No/Street/PO Box	City/Town	Province	Postalcode(A1A 1A1)
420 NA'A PLAZA	CALGARY	AB	T3H 6A4

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
[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):*
    29/10/2021

20. Time of Immunization(If Known)(00:00:00)
    14:00:00

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	Yes	10/30/2021
Other	10/30/2021	No	
None		None	
None		None	

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

Syncope (resolved), dyspnea/palpitations (unresolv

24. Additional Information:

had COVID Sept 15/21, then recovered - NO SYMPTOMS after recovery
had some dizziness then lost weight as well, bad cough as well
after 1 month - was encouraged to have vaccine as per government and to play hockey
had 1st dose of PFIZER Oct 29/21 1400 - Save on Foods Trinity Hills
Oct 30/21 early morning found on the ground (0600h)
mom could not find a pulse, unresponsive, 911 EMS arrived
brought to hospital to be checked at ACH
felt light in the chest
no headache
very fatigued
investigations performed, then released
told by ER physician that this was an adverse reaction to the vaccine
no further syncope

Nov 2/21 "Dryland episode" - doing more physical activity then appeared pale, was feeling cold
headache, then felt like he was going to pass out
heart not feeling right
could not participate in sports due to recurrent symptoms

has tried practices since, no weight training since (due to cold sensation, pale appearance,
malaise when working out)

occasional headache and dizziness, consistently appears pale after skating
some palpitations with minimal activity

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*
   26/11/2021

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
Rexall Ponoka	Pharmacy	

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

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):*
    15/10/2021

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 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)
Severe Diarrhe	11/04/2021	No	
None		None	
None		None	
None		None	

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

diarrhea

24. Additional Information:

severe diarrhea and abdominal cramping 1st week of November (2 weeks after the 2nd injection)
no blood or mucous, but watery stools
cramping better with imodium and pro-biotics
still having 4-5 bowel movements per day

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

Jan 12, 2022

GC/PS

request for medical records from AEFI
verbal consent has been given from pt to go ahead and send
Sent by fax to 780-342-0248
ok'd by Dr Chan
Panel Manager: Penny Skjonsberg, Jan 12, 2022, 10:17AM

Jan 12, 2022

GC/PS

call from Michelle with AHS-587-943-1665
wanting information regarding vaccine after effects -AEFI
call with Dr Chan wanted
?requires further testing
?recommendations for further vaccines
spoke to Dr Chan
he said to tell them that he writes all the information as discussed with pt about symptoms and follows all guidelines as per website on AEFI form before submitting
if more information is required they can send a fax
Advised to speak to the patient also
Panel Manager: Penny Skjonsberg, Jan 12, 2022, 10:50AM

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*
   26/11/2021

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
Rexall Ponoka	Pharmacy	

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

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):*

    15/10/2021

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 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	11/23/2021	No	
None		None	
None		None	
None		None	

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

Tinnitus

24. Additional Information:

new onset of tinnitus this week, recent immunization is the only new medication/procedure in the last 4 weeks. NO PREVIOUS TINNITUS.
no symptoms when waking up, but low tone develops and increases/decreases through the day
physical exam is normal aside from mild irritation in the nasal passage

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.

SCANNED

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*
   29/11/2021

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
Maskwacis Health Center	Public Health	

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

9. Immunizing Facility Address

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

MINDE AVE & W MASKWACIS AB T0C 1N0

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:*

M-Male

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

16. PHN/ULI Info:

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

18. Patient Address:

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

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

18/11/2021

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.
COVMODmF	MODTH-Moc	
-- 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	11/28/2021	No	
None		None	
None		None	
None		None	

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

peripheral neuropathy

24. Additional Information:

3rd dose of Moderna Nov 18/21. 1st dose Jan 22/21, 2nd dose Feb 26/21.
2nd visit to ER with migrating/progressive neurological symptoms starting in the last 12 hours. This is 10 days post 3rd dose. He noticed some weakness to hands last night then came to the ER. Sent home. The lower extremities seem to be involved today (not yesterday)
BP is slightly low 98/72, HR normal.
MED: Epilepsy; HTN; dyslipidemia; Brain injury remote Hx; Atrial fibrillation

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*
   21/12/2021

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
Parson's Pharmacy	Pharmacy	

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

9. Immunizing Facility Address

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

1C – 4755 49TH	RED DEER	AB	T4N 1T6

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):*
    21/06/2021

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)
Rash	07/19/2021	No	
None		None	
None		None	
None		None	

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

rash

24. Additional Information:

```
initial rash on right arm, clustered raised erythematous lesions
then lesions on plantar surface 3rd digit right foot - blister with erythematous background,
additional lesions on 1st digit with bruising
now lesions on left arm raised with hypopigmentation at the periphery, raised, pruritic -
targetoid lesions clustered circular lesions 2-3 grouped
```

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

Jan 31, 2022 SG

note [redacted] AHS AEFI said no contraindications for next vaccine

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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*
   6/1/2022

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 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:*
    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):*
    23/12/2021

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.
COVMODmF	MODTH-Moc	
-- 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	01/05/2022	No	
Other	12/23/2021	Yes	12/25/2021
None		None	
None		None	

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

fatigue, malaise, arm pain

24. Additional Information:

OTHER - fatigue malaise arm pain on same day as the injection (3rd dose)
doses 1 and 2 had no arm pain or fatigue or malaise
PAIN - chest pain onset 2230 Jan 5/22, left sided. Pleuritic. Some dyspnea occurs when deep breathing. Chest pain continued today. Had episode Dec 21/21 but it resolved.
ECG normal, CK troponin normal. D-dimer 0.13. Lipase >800.
CT chest/abdo/pelvis pending
exercise stress test pending
advised to take aspirin daily until stress test result available

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

Jan 31, 2022

PS

[redacted] with AHS-587-782-4345
recommendations from Medical officer of Health
Recommends further dose of Covid 19 vaccines can not be made at this time until further research is available. AHS has reported suspected myocarditis to Alberta Health
Note to Dr Chan to review
Panel Manager: [redacted], Jan 31, 2022, 3:44PM

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

Feb 8, 2022 PS

AEFI 587-786-6448
wondering if shortness of breath is related to the infection of Covid or from the vaccine
any upcoming testing
booked in for a call as per DR CHan to discuss
Panel Manager: , Feb 8, 2022, 11:12AM

Feb 10, 2022 GC

Dr. Gregory Chan, February 10, 2022, 10:22AM
**** COVID-19 telephone conversation ****
discussion with AEFI
chronology fits with vaccine
advised
Dr. Gregory Chan, February 10, 2022, 10:23AM

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![Alberta Health Services]

Alberta Health Services

AEFI Reporting Form

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1. Today's Date*
   17/1/2022

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 Shoppers 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 0J1

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):*

    17/11/2021

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.
COVPBmR	BPF-BioNTe	
-- 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)
Other	20/12/2021	No	
None		None	
None		None	
None		None	

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

Dyspnea with minimal exertion

24. Additional Information:

2nd COVID injection Nov 17/21
mid December has noticed an increase in dyspnea with MINIMAL exertion
progressively worse
had COVID Dec 31/21
dyspnea is persistent, can get dyspnea with 2 steps or talking
previously active, weight lifting, sports (competitive)
arranging ECHO and PFT and 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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SCANNED

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*
   17/1/2022

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	PONOKA	AB	T4J 1S3

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

Central

11. Patient LastName*

Jensen

12. Patient FirstName*

Peter

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 -,())

403-704-5351

16. PHN/ULI Info:

172254900

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

01/08/1946

18. Patient Address:

Building No/Street/POBox	City/Town	Province	PostalCode(A1A 1A1)
5512-57 AVE UN	PONOKA	AB	T4J 1V7

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

28/09/2021

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-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	10/14/2021	No	
None		None	
None		None	
None		None	

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

urinary retention

24. Additional Information:

patient started to have urinary retention about 2 weeks after the 2nd COVID vaccine
progressively worse each week
November, AFTER THE VACCINE and AFTER THE ONSET OF SYMPTOMS, had treatment for prostate cancer (radiation)
Operative report from December cystoscopy - "The bladder was examined, and there were no gross abnormalities seen. No tumor, masses, or any stones."

Prior to 2nd dose (September 2021) - no urinary retention symptoms

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

Feb 7, 2022 PS

[redacted] from AEFI team 587-773-2035
wants to discuss her symptoms and if any treatments and when D Chan spoke to her
as per dr chan I have made her a telephone appt under pts name
Panel Manager: [redacted] Feb 7, 2022, 9:43AM

Feb 8, 2022 GC

Dr. Gregory Chan, February 8, 2022, 11:52AM
**** COVID-19 telephone conversation ****
discussed AEFI with [redacted]
wanting to clarify, but I simply REITERATED the previous information on the submitted form
Dr. Gregory Chan, February 8, 2022, 11:52AM

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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*
   19/1/2022

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
Pharmasave Clive	Pharmacy	

8. Immunization Facility Phone#
   (only numbers, no -,())
   403-784-0421

9. Immunizing Facility Address

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

- CLIVE 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:*
    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):*
    25/10/2021

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	FF2595
-- 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	10/28/2021	Yes	12/01/2021
None		None	
None		None	
None		None	

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

numbness around mouth

24. Additional Information:

```
patient described numbness around the mouth developing days after SECOND DOSE of Pfizer
NEVER has symptoms like this previously
took several weeks to resolve
did not seek medical attention, no treatment
```

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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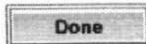

Jan 31, 2022 GC/PS

Verbal consent given to send AHS requested notes for AEFI
faxed to 1-780-342-0248
Panel Manager: [redacted], Jan 31, 2022, 12:05PM

Jan 31, 2022 PS

[redacted] from AHS-780-702-2653
all info was sent and now asking for
1. Current Diagnosis
2. Treatment plan
3. Assessment plan
I have printed off the AEFI form as I believe all information is there, will confirm with Dr Chan
and if he wants to add anything
Will contact [redacted]
Panel Manager: [redacted], Jan 31, 2022, 3:06PM

Feb 1, 2022 GC

discussion with [redacted] from AEFI
no physical exam done
I explained that the chronology seems to fit with a vaccine injury
It doesn't meet criteria according to AEFI
Dr. Gregory Chan, February 1, 2022, 3:40PM

Feb 2, 2022 PS

AHS asking for reports for pt
advised they were already sent to [redacted] on Jan 31/2022
will send again and will provide AEFI form as well
Panel Manager: [redacted], Feb 2, 2022, 11:38AM

Feb 3, 2022 GC/PS

as per [redacted] at AEFI 780-702-2653
After review no contradiction of COVID 19 Vaccine .
Panel Manager: [redacted], Feb 3, 2022, 4:04PM

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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*
   19/1/2022
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
Rexall Ponoka	Pharmacy	

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

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

4502 - 50TH ST 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):*

    03/12/2021

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	12/04/2021	No	
None		None	
None		None	
None		None	

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

Severe symptoms - fatigue, malaise, myalgias

24. Additional Information:

patient HAD COVID Sept 15, 2021
was advised to have vaccination anyways, and had 1st dose Dec 3, 2021
symptoms include myalgia, arthralgias, chest pain, back pain
progressive each day and week since vaccine
severe enough to have multiple ER visits Dec 5, Dec 19
clinic visit Dec 15 - also noted worsening dyspnea; referral to respirology and echocardiogram - I was concerned about myocarditis
echocardiogram normal
Dec 5 mild elevation of D-dimer 0.54, Hb 115, CRP 56; VQ scan negative for PE
Dec 15 - seen and advised to try short course of high dose aspirin 325mg daily
Dec 19 hemoglobin 106
Jan 13 labwork showed decline in hemoglobin WITHOUT EVIDENCE of hemorrhage (Hb ~94), normocytic
massive elevation of ferritin > 2192 and CRP > 226
being treated for polymyalgia rheumatica (suspected) with prednisone
iron for anemia
awaiting consult for endoscopy to investigate other causes of anemia

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

Feb 17, 2022 GC/PS

[redacted] AEFI
appt has been made to speak with Dr Chan
Panel Manager: [redacted], Feb 17, 2022, 3:51PM

Feb 18, 2022 GC

Dr. Gregory Chan, February 18, 2022, 9:52AM
discussion with AEFI [redacted]
discussed Historical/Forensic Science vs Observation/Experimental Science
Dr. Gregory Chan, February 18, 2022, 9:56AM

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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*
   11/2/2022

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):*
    07/01/2022

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.
COVMO	MODTH-	
-- Please	-- Please	

-- Please | -- Please
-- Please | -- Please
-- Please | -- Please

22. Adverse Event Info:

Symptoms	Started Date (mm/dd/yyyy)	Resolved?	Resolved Date (mm/dd/yyyy)
Pain and/or :	01/09/2022	No	
None		None	
None		None	
None		None	

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

shoulder pain

24. Additional Information:

patient had her booster injection Jan 7/22, and within 2-3 days had shoulder pain that was significantly worse, subjectively different from previous shoulder pain
lasted 3-4 weeks
now has pain that migrates from one area of the body to another, mild in severity
similar episode in July/Aug 2021 after 2nd dose in June 2021 but it was MILD
had pain in the shoulder/back after dry needling, stopped once she stopped dry needling
never had muscle/arm/back pain like this with previous immunizations

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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Feb 22, 2022

GC/PS

[redacted]- AEFI 587-782-4345
"pt can go ahead with future vaccines for MRNA/Covid"
noet to Dr Chan
Panel Manager: [redacted] Feb 22, 2022, 11:33AM

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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*

   11/2/2022

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
No Frills	Pharmacy	

8. Immunization Facility Phone#

   (only numbers, no -,())

9. Immunizing Facility Address

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

5561 HWY 53 PONOKA AB T4J 1J8

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):*

09/01/2022

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.
COVPBr	BPF-Biol	
-- Please	-- Please	

-- Please	-- Please
-- Please	-- Please
-- Please	-- Please

22. Adverse Event Info:

Symptoms	Started Date (mm/dd/yyyy)	Resolved?	Resolved Date (mm/dd/yyyy)
Other	01/11/2022	No	
None		None	
None		None	
None		None	

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

hot flashes

24. Additional Information:

has had menopause and hot flashes which RESOLVED about 1.5 years ago
had vaccine, 1st dose Jan 9/22 - then has had hot flashes again for the last 4 weeks, not resolving

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.

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*
   17/4/2022
2. Reporter(Your) LastName*
   Chan
3. Reporter(Your) FirstName*
   Gregory
4. Reporter (Your) SiteType:*
   AHS Acute Care
5. If Other SiteType, please specify:
6. Reporter(Your) Phone#*
   (only numbers, no -,())
7. Immunization Facility:

Name	SiteType	If other SiteType, please specify
Centennial Center for Mental	AHS Acute Care	

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

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

46 STREET S	PONOKA	AB	T4J 1R8

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

11. Patient LastName*
    Smith

12. Patient FirstName*
    Greg

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 -,())
    403-396-3702

16. PHN/ULI Info:
    482304720

17. Date Of Birth(dd/mm/yyyy)*
    05/01/1984

18. Patient Address:

Building No/Street/POBox	City/Town	Province	PostalCode(A1A 1A1)
6102-51 STREET	PONOKA	AB	T4J 1E7

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.
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	09/10/2022	No	
None		None	
None		None	
None		None	

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

change in bowel consistency

24. Additional Information:

prior to 1st COVID injection - normal bowel movement size and consistency
was admitted to hospital (Centennial Center for Mental Health and Brain Injury), was given 1st injection as an inpatient
within 24 hours of 1st injection - had smaller size flat bowel movements with episodes of diarrhea and small volume stool
chronic abdominal pain, Left lower quadrant and left flank
worse in the last 1-2 months
presented to ER with abdominal pain and reported change in stool
Slight increase in WBC/neutrophil count
Slight elevation of ALT
Plan - needs colonoscopy and abdominal US

Summary - since 1st injection, bowel movements have significantly changed in consistency and frequency, and have not returned to pre-injection bowel movement consistency/frequency

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*
   24/5/2022

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
Maskwacis Health Services	First Nations and Inuit He:	

8. Immunization Facility Phone#
   (only numbers, no -,())
   780-585-3830

9. Immunizing Facility Address

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

MINDE AVE & W	MASKWACIS	AB	T0C 1N0

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):*

    11/05/2021

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.
COVMODmF	MODTH-Moc	
-- 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)
Rash	05/18/2021	No	
None		None	
None		None	
None		None	

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

Rash

24. Additional Information:

rash developed in LEFT antecubital fossa 1 week after 2nd MODERNA COVID vaccine
patient has never had eczema
rash has slowly increased in size, about 5x6cm

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

Sep 19, 2022 GC

discussed with [redacted]
does not meet criteria because no bloodwork drawn immediately after 3rd dose documented
recommendation to continue with the vaccines
Dr. Gregory Chan, September 19, 2022, 1:59PM

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Alberta Health Services

AEFI Reporting Form

Page 1 of 1

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
   15/9/2022
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
Shoppers 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)
5015-50 STREET	PONOKA	AB	T4J 0C1

10. Select Zone: (Click here to determine zone.)
    Calgary
11. Patient LastName*
12. Patient FirstName*
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 -,())
16. PHN/ULI Info:
17. Date Of Birth(dd/mm/yyyy)*
18. Patient Address:

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

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

23/12/2021

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

14:25:00

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

Vaccine Code	Manufacturer	LotNo.
COVPBmRNA	BPF-BioNTec	28-227-DK
-- 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)
Rash	01/10/2022	No	
None		None	
None		None	
None		None	

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

bruising, ecchymosis

24. Additional Information:

about 2 weeks after booster injection - bruising and ecchymosis
with minimal trauma
not present prior to booster 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

Feb 1/23 @2:17. → away till Monday can call then

RH 69460

Ponoka, AB

M

c̄ AHS.

AFI outcome
Does not meet criteria for myocarditis.
All cardio tests were normal
she asks that you review the "criteria" on the AHS website

/A

P.S
I did advise her that I was sure you were fully aware of the "criteria"

/A

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 any adverse event following immunization, please call Health Link at 811 or contact your health provider.

1. Today's Date*
   30/12/2022

2. Reporter(Your) LastName*
   CHAN

3. Reporter(Your) FirstName*
   Gregory

4. Reporter (Your) SiteType:*
   AHS Acute Care

5. If Other SiteType, please specify:

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

7. Immunization Facility:

Name	SiteType	If other SiteType, please specify
Rexall Ponoka	Pharmacy	

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

9. Immunizing Facility Address

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

4502 50 ST	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):*

    22/10/21

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	10/24/2021	No	
Other	10/24/2021	No	
None		None	
None		None	

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

dyspnea, palpitations, dizziness

24. Additional Information:

Patient had 1st dose of PFIZER and 2 days later. Intermittent symptoms. Multiple ER and GP visits. Cardiology consultation Dec 5/21. Echocardiogram, Dec 2/21 and cardiac MRI Nov 25/22 unremarkable, though the tests occurred much after the vaccination event.

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*

   17/1/2023

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
Pharmacy	Pharmacy	unknown

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

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:*
    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):*
    16/03/2021

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 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)
Pain and/or Swe	03/16/2021	Yes	03/20/2021
Other	03/16/2021	Yes	03/20/2021
None		None	
None		None	

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

diarrhea, weakness

24. Additional Information:

```
left sided face scalp face pain, then trigger migraine
crawling on floor
diarrhea
recovered after about 1 week
no reaction with Pfizer, went to Calgary 'in case she had an adverse reaction'
```

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

AEFI Reporting Form

Page 1 of 1

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*
   10/2/2023

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:*
    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):*
    13/11/2021

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.
COVPBmRNA	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	12/01/2021	Yes	04/01/2022
Other	03/16/2022	Yes	18/07/2022
None		None	
None		None	

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

1. CHEST PAIN, 2. elevated ferritin

24. Additional Information:

1. Chest pain - within 2 weeks of 2nd Pfizer COVID mRNA injection - developed chest pain when working under a car. Never had chest pain like this previously. Had seen his GP and she ordered a cardiology consultation.
As per notes from Netcare Cardiology consultation:
"As you know, this gentleman experienced some chest pain in early December of 2021. He was under a car changing oil. The pain lasted for about 20 minutes. There was a sensation of cramping over the area of his heart. There was no associated shortness of breath, nausea, or diaphoresis. He had further pain in early March of this year, which again lasted for about 20 minutes. He had been lifting some heavy boxes. There is no associated shortness of breath or nausea."
Chest pain has since resolved, no exertional chest pain or pain at rest
2. Elevated ferritin.
Known to have slightly elevated ferritin. Investigated prior to vaccination and max was mid 600s. After vaccination his March 2022 Ferritin was > 1100. After phlebotomy the number has reduced to normal range. Still followed by gastroenterologist in Red Deer

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

-- Please Select --

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

-- Please Select --

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*
   14/11/2021

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
Roots & Berries Pharmacy	Pharmacy	

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

9. Immunizing Facility Address

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

14 ERMINESKIN	MASKWACIS	AB	T0C 1N0

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:*
    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):*
    18/10/2021

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-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)
Severe Diarrhea	11/06/2021	No	
None		None	
None		None	
None		None	

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

diarrhea, cough, congestion

24. Additional Information:

2nd dose of PFIZER
onset Nov 6/21 - diarrhea (non bloody, about 3 per day, no mucous), abdominal pain, cough (non-productive), sore throat (this has resolved on Nov 11/21)
diarrhea has not 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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Done