

SCANNED

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*			
	15/11/2021			
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 -,())			
				Tanga Internalia
7.	Immunization Facility:			If other SiteType, please
	Name	Si	teType	specify
	Maskwacis Health Serv	rices Public Heal	th 🕶	
	Waskwadis Health 501			
8.				
	(only numbers, no -,())			
	The state of the s			

9. Immunizing Facility Address

Building No/Street/PO Box

City/Town

Province

Postalcode(A1A 1A1)

 Select Zone: (Click ½ Central ✓ 	<u>nere</u> to determine zone	.)		
11. Patient LastName*				
Minde				
6 Hope and John Service				
12. Patient FirstName*				
and the second				
13. If Patient is a minor, the	n Parent/Guardian			
	LastName	FirstName	RelationToPatient	
	-	-	-	
14. Patient Sex at Birth:*				
F-Female 🗸				
15. Patient/Guardian Phone# (only numbers, no -,())	£*			
780-839-8882				
16. PHN/ULI Info:				
106220230				
17. Date Of Birth(dd/mm/yyy	(Y)*			
24/01/1991				
18. Patient Address:				
	Building No/Street/POBox	City/Town	Province	PostalCode(A1A
	BOX 1228	MASKWACIS	AB	1A1) TOC 1NO
 Date Of Immunization(dd/ 21/10/2021 	/mm/yyyy):*		no o stance) i i mon sprav	
0. Time of Immunization(If K 00:00:00	nown)(00:00:00)			
List all the vaccines given of Immunization Information:	on date of immunization	n.		

Manufacturer

MODTH-Moc **▼**

Unknown/Otf ✔

LotNo.

Vaccine Code

COVMODmF **▼**

Influenza (Aç ✔

Please Sel ♥	Please Sel ➤	
Please Sel 🗸	Please Sel ♥	
Please Sel 🗸	Please Sel ♥	

Sympto	oms	Started Date (mm/dd/yyyy)	Resolv	ed?	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.





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

- Today's Date*
 18/11/2021
- Reporter(Your) LastName*
 CHAN
- Reporter(Your) FirstName* Gregory
- Reporter (Your) SiteType:*
 Physician ✓
- 5. If Other SiteType, please specify:
- Reporter(Your) Phone#* (only numbers, no -,())



7. Immunization Facility:





Name

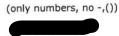
SiteType

If other SiteType, please specify

Ponoka Professional Pharma

-- Please Select --

8. Immunization Facility Phone#



9. Immunizing Facility Address

Building No/Street/PO Box

City/Town

Province

Postalcode(A1A 1A1)

10.		nere to determine zor	ne.)		
	Central 🗸				
11.	Patient LastName*				
	Dux				
12.	Patient FirstName*				
	Varielle on home big no				
13.	If Patient is a minor, the	en Parent/Guardian			
		LastName	FirstName	RelationToPati	ent
1.4	Potiont Court Dist				
14.	Patient Sex at Birth:* F-Female				
	1 - Citale				
15.	Patient/Guardian Phone	#*			
	(only numbers, no -,())				
	403-704-3385				
16.	PHN/ULI Info:				
	515801420				
17.	Date Of Birth(dd/mm/y	yyy)*			
	04/12/1984				
18.	Patient Address:				
		Building	City/Town	Province	PostalCode(A1A
		No/Street/POBo	x x		1A1)
		RKI, SHE II, B	PONOKA	AB	T4J 1R1 elintine not
	Date Of Immunization(d				
13.	30/09/2021	ia/mm/yyyy):*			
20.	Time of Immunization(If	f Known)(00:00:00)			
	00:00:00				
	List all the vaccines give Immunization Information		zation.		
		Vaccine Code	Manufacturer	LotNo.	

Manufacturer

MODTH-Mc ✓

-- Please Si 🗸

COVMOD# >

-- Please Si 🗸

LotNo.

Please S₁ ✔	Please Si 🗸
Please S₁ ✓	Please Si 🗸
Please Si 🗸	Please Si 🗸

Sympt	oms	Started Date (mm/dd/yyyy)	Resolv	ved?	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.

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.

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 pin 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:

Jan 19, 2022, 10:10AM

Feb 7, 2022

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

Feb 7, 2022, 1:51PM Panel Manager:

Feb 8, 2022

AEFI

wanting to close file

would like an appt to discuss, she said has a few questions to finish up

PS

GC/PS

Birth date #62329 took the call they decided to make her an appt to discuss Mar 3/2022 for a call Panel Manager: Cenny Feb 8, 2022, 12:01PM Feb 8, 2022 KS AEFI called regarding multiple attempts to contact Dr. Giber regarding patient history. Asked Penny to make an appointment for Dr. Gilberto call Gigrin 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? 创新国际部础制 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





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.

- Today's Date*
 18/11/2021
- Reporter(Your) LastName*CHAN
- Reporter(Your) FirstName* GREGORY
- Reporter (Your) SiteType:*
 Physician ✓
- 5. If Other SiteType, please specify:
- Reporter(Your) Phone#* (only numbers, no -,())



7. Immunization Facility



SiteType

If other SiteType, please specify

學山利斯西州鄉

Shopper's Drug Mart Ponoka Pharmacy

Name

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



9. Immunizing Facility Address

Building No/Street/PO Box

City/Town

Province

Postalcode(A1A 1A1)

10	0. Select Zone: (Clic	k <u>here</u> to determine zo	one.)		
	Central 🗸				
11	I. Patient LastName*				
	Cunningham				
	10 : 9581				
4.5					
12	2. Patient FirstName*				
	Kendall				
13	. If Patient is a minor, t	then Parent/Guardian			
		LastName	FirstName	D.I	
		-	institutie	RelationToPatie	nt statement
				-	
1.4	Dati I O				
14	. Patient Sex at Birth:*				
	F-Female V				
15.	. Patient/Guardian Phor	ne#*			
	(only numbers, no -,())				
	780-863-1844				
16.	PHN/ULI Info:			4.	
	6004734BD				
17	Date Of Birth/dd/mm/				
17.	Date Of Birth(dd/mm/	уууу)*			
	Carlo Hara				
18.	Patient Address:				
		Building	52 W. C. 180000		PostalCode(A1A
		No/Street/POBo	City/Town	Province	1A1)
		5105-58 AVE	PONOKA		4J 1G3
					MARKE MINISTER
	Date Of Immunization				
	21/10/2021	(,,,,,,,			
20	Time of Terror				
20.	Time of Immunization(If Known)(00:00:00)	NAME OF TAXABLE PARTY O		
	00:00:00		5		
21.	List all the vaccines giv	en on date of immuniz	zation.		
	Immunization Informat	ion:			
		Vaccine Code	Manufacturer	LotNo.	
		COVPBmR ✓	BPF-BioNT₁ ✓	griblies	
		Please St >	Please St V		

Please S₁ ✓	Please St 🗸
- Please S₁ ✔	Please Si 🗸
Please S₁ ✓	Please Si 🗸

Sympto	oms	Started Date (mm/dd/yyyy)	Resolv	red?	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.

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.

Birth date #6615 Page 1/1 GC/PS Jan 7, 2022 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 onsberg, Jan 7, 2022, 12:54PM Panel Manager: discussed with agreed that itching is an adverse reaction, will be reported to MOH Dr. Gregory Chan, January 7, 2022, 1:59PM PS Jan 10, 2022 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 Jan 10, 2022, 1:08PM Panel Manager:

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



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*		
	19/11/2021		
			WANTE STATE OF THE STATE OF
2.	Reporter(Your) LastName*		
	CHAN		
3.	Reporter(Your) FirstName*	participant d	
	GREGORY		
4.	Reporter (Your) SiteType:*		
	Physician C		
5.	If Other SiteType, please specify:		
6.	Reporter(Your) Phone#*		
0.	(only numbers, no -,())		
	403-783-3399		6 - 4 - 40
7.	Immunization Facility:		17. Osta Oli Barta (slidy myr. yyny)
	Name	SiteType	If other Site type, ple se specify
	Rexall Ponoka	Pharmacy	
	Prophetical Control of the Control o		
8.	Immunization micility none#		
٥.	(only numbers, no -,())		
		magazana re-	

9.	Immunizing Facility Addi				
		Building No/Street/PO	City/Town	Dunning	Postalcode(A1A
		Вох	City/ Town	Province	1A1)
		BAY 3, 4502-50 ST	PONOKA	AB	T4J 1J5
	110 1 3 6 1 7				
10.	A CONTRACTOR OF THE PARTY OF TH	re to determine zone	.)		
	Central				
11.	Patient LastName*				
	Cumington				
		Miles 1 - 4-1 - 6-2 may 1-4-2 - 6-2 may 1-2-4 - 1-4 may 1-4 ma			
12.	Patient FirstName*				
	Coreen				
13.	If Patient is a minor, then	Parent/Guardian			
		LastName	FirstName	RelationToPatient	
		-	-	-	
2					
14.	Patient Sex at Birth:*				
	F-Female 💠				
15.	Patient/Guardian Phone#	*			
	(only numbers, no -,())				
	(103-304-5483)				
16.	PHN/ULI Info:				
	382041600				
17	Data Of Birth (dd/mars/				
17.	Date Of Birth(dd/mm/yyy	y)*			
18.	Patient Address:				
	. Estatic riddi caa.	Building			
		No/Street/POBox	City/Town	Province	PostalCode(A1A

1A1)

Started Date	28/05/2021						
List all the vaccines given on date of immunization. Immunization Information: Vaccine Code BPF-BIONTec C Please Seli C Please	Time of Immuni	zation(If Known)(00:0	0:00)				
List all the vaccines given on date of immunization. Immunization Information: Vaccine Code BPF-BioNTec © Please Sel: ② Please Sel:	00:00:00						
List all the vaccines given on date of immunization. Immunization Information: Vaccine Code Wanufacturer COVPBMRNA		Torrest Activities he					
Vaccine Code	List all the wassi	nos given on date of i	mmunization	dispert of the C			
Vaccine Code COVPBmRNA			Jasen val yhi	self-indome			
COVPBMRNA © BPF-BioNTec © Please Seli © Plea	Illinumzación II		Codo Ma	nufacturer	LotNo.		
Adverse Event Info: Symptoms Other Of/28/2021 None None					of produced to 21.		
Adverse Event Info: Symptoms Started Date (mm/dd/yyyy) Other O5/28/2021 None None None None None None None None	٠	COVPBMR					
Adverse Event Info: Symptoms Started Date (mm/dd/yyyy) Other O5/28/2021 No O None None None None None None None None		Please	Sel O I	lease Seli C			
Adverse Event Info: Started Date (mm/dd/yyyy) Other		Please	Sel 🗘 [[Please Seli			
Adverse Event Info: Symptoms		Please	Sel 0	Please Selc C			
Symptoms Started Date (mm/dd/yyyy) Other O5/28/2021 No None		Please	Sel 0 (Please Seli C			
Symptoms Started Date (mm/dd/yyyy) Other O5/28/2021 No None							
Symptoms Started Date (mm/dd/yyyy) Other O5/28/2021 No None							
Other	Adverse Event	inio:		and Date			Resolved Date
None		Symptoms			Resolved	1?	(mm/dd/yyyy)
None		Other	05/28/	2021	No		
None		None	0)		None	0	
None		None	0		None	0)	
If other, describe including Started date & Resolved date: Pruritis 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 suggest 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 5. Patient is aware that you are reporting the AEFI description and patient contact information to Alberta Healti Services AEFI follow-up.*		None	0		None	•	
Pruritis 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 suggest 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 5. Patient is aware that you are reporting the AEFI description and patient contact information to Alberta Health Services AEFI follow-up.*							
Pruritis 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 suggest 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 5. Patient is aware that you are reporting the AEFI description and patient contact information to Alberta Health Services AEFI follow-up.*		· . . Ct t	ata 9. Basaly	od date:			
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 suggest 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 6. Patient is aware that you are reporting the AEFI description and patient contact information to Alberta Healti Services AEFI follow-up.*	p	be including Started d	ate & Resolve	d date.			
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 suggest 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 6. Patient is aware that you are reporting the AEFI description and patient contact information to Alberta Health Services AEFI follow-up.*	Pruritis			1			
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 suggest 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 5. Patient is aware that you are reporting the AEFI description and patient contact information to Alberta Health Services AEFI follow-up.*		•					
treated on site by EMS told to take Benadryl before the 2nd dose (as per paramedics) - physician in Red Deer giving cortisone injections also sugges 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 Patient is aware that you are reporting the AEFI description and patient contact information to Alberta Healt Services AEFI follow-up.*	. Additional Info	rmation:					
treated on site by EMS told to take Benadryl before the 2nd dose (as per paramedics) - physician in Red Deer giving cortisone injections also sugges 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 Patient is aware that you are reporting the AEFI description and patient contact information to Alberta Healt Services AEFI follow-up.*	1st injection May	28/21 - had itching imme	ediately afterw	ard, rapid HR, seve	ere, called 811 and t	then advised	to call 911
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 Patient is aware that you are reporting the AEFI description and patient contact information to Alberta Healt Services AEFI follow-up.*							
pharmacy itching persists today, worse in warm environments • Patient is aware that you are reporting the AEFI description and patient contact information to Alberta Health Services AEFI follow-up.*							
itching persists today, worse in warm environments 4 5. Patient is aware that you are reporting the AEFI description and patient contact information to Alberta Health Services AEFI follow-up.*	2nd injection Jul	y 7/21 - had itching wors	ened and flush	ng immediately af	terwards, was giver	n an injection	1 Of Benadi yr at the
5. Patient is aware that you are reporting the AEFI description and patient contact information to Alberta Health Services AEFI follow-up.*	itching persists	today, worse in warm env	ronments				
Services AEFI follow-up.*	Treatming persons	•					
Services AEFI follow-up.*							
Services AEFI follow-up.*			ng the AEET	description and	natient contact is	nformation	to Alberta Health
			ing the AEPI	Jescription and	patient contact ii		
	Services AEFI						

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

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

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.



#2503 Birth date

Jan 21, 2022

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:

Jan 21, 2022, 2:43PM

Jan 28, 2022

discussed with 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

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

GC

GC

GC/PS

Printed by GC on Mar 23, 2022 12:13





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* 25/11/2021 Reporter(Your) LastName* CHAN Reporter(Your) FirstName* GREGORY 4. Reporter (Your) SiteType:* Physician 5. If Other SiteType, please specify: Reporter(Your) Phone#* (only numbers, no -,()) 7. Immunization Facility: If other SiteType, please SiteType Name specify Pharmacy Save-On-Foods Trinity Hills

 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

1	0. Select Zone: (Click here to	determine zo	ne.)		
	Calgary ~				
1	1. Patient LastName*				
	Bishop				
	Carlot of artists				
1	2. Patient FirstName*				
	Liam				
13	3. If Patient is a minor, then Parer	t/Guardian			
		LastName	FirstName	RelationToPatient	
		hop	Jennifer	Mother	
		_	-		
14	1. Patient Sex at Birth:*				
	M-Male 🗸				
15	. Patient/Guardian Phone#*				
	(only numbers, no -,())				
	403-963-3430				
	B				
16	. PHN/ULI Info:				
	1010/0921				
17	Date Of Bitle (11)				
17	Date Of Birth(dd/mm/yyyy)*				
18	Patient Address:				
		Building	City/Town	Province	PostalCode(A1A
	NO/S	treet/POBo			1A1)
		CITECADITIE	GALGAIN		T3B 6J2
19.	Date Of Immunization(dd/mm/y				
	29/10/2021	yyy): *			
20		(00.00.00)			
20.	Time of Immunization(If Known) 14:00:00	(00:00:00)			
	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
21.	List all the vaccines given on date	of imam !	-11		
	Immunization Information:	e or immuniz	ation.		
	Vac	ine Code	Manufacturer	LotNo.	
		PBmR ✓	BPF-BioNT(✓		
	Ple	ase Si 🗸	Please S _t 🗸		
		ase Sr 🗸	Please S ₁ V		
	Ple	ase Si 🗸	Please St V		
	AAD HET	250 Oi •	Flease St V		

Sympto	oms	Started Date (mm/dd/yyyy)	Resolv	red?	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.

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.



26/11/2021



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

1. Today's Date*

2.	Reporter(Your) LastName*					
	CHAN					

3. Reporter(Your) FirstName*

GREGORY

- Reporter (Your) SiteType:*
 Physician ✓
- 5. If Other SiteType, please specify:
- Reporter(Your) Phone#* (only numbers, no -,())
- 7. Immunization Facility:





SiteType

Rexall Ponoka

Name

Pharmacy

If other SiteType, please specify

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



9. Immunizing Facility Address

Building No/Street/PO Box

City/Town

Province

Postalcode(A1A 1A1)

AB

10	. Select Zone: (Click <u>here</u> to determine zone	2.)		
	Central 🗸	,		
11.	. Patient LastName*			
	St. Denis			
	Manager at the Chapter St			
12.	Patient FirstName*			
	Jayden of been bits allows through an 130 redire			
	mental your health provides.			
13.	If Patient is a minor, then Parent/Guardian			
	LastName	FirstName	Dalada T. B. H	,=Tp.1 (AB00),
	-	-	RelationToPatie	nt assumes
14.	Patient Sex at Birth:*			
	F-Female >			
15.	Patient/Guardian Phone#*			
	(only numbers, no -,())			
	403-783-1960			
16.	PHN/ULI Info:			
	878549880			
17.	Date Of Birth(dd/mm/yyyy)*			
	04/11/1996			
10	Patient Address:			
10.				
	Building No/Street/POBox	City/Town	Province	PostalCode(A1A
	6001-42A STREE	PONOKA		1A1)
	and the second s			GIES PLEEN
	Date Of Immunization(dd/mm/yyyy):*			
13.	15/10/2021			
20				
20.	Time of Immunization(If Known)(00:00:00)			
	00:00:00			
2.	reached and			
	List all the vaccines given on date of immunization information:	tion.		
	Vaccine Code	Manufacturer	LOUNG.	
	COVPBmR ✓	BPF-BioNTi 🗸		

-- Please Si 🗸

- Please Si 🗸

Please S₁ ∨	Please Si 🗸
Please S₁ ✓	Please St 🗸
- Please St V	Please St 🗸

Symptoms		Started Date (mm/dd/yyyy)	Resolv	ved?	Resolved Date (mm/dd/yyyy)
Severe Dia	arrhe 🗸	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.

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.

Birth date (5/09/1978) #826 Page 1/1

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 Skionsberg, Jan 12, 2022, 10:17AM

Jan 12, 2022

GC/PS

call from 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: Tenny Skjonsberg, Jan 12, 2022, 10:50AM



AEFI Reporting Form $i_{\frac{n}{2}l}$



Postalcode(A1A

1A1)

Province

nly. If you are a member of the general public and need to report

	Note: This form is for health care adverse event following immuniz	ation, please call H	ealth Link at 811 or	contact your hea	Ith provider.	
1.	Today's Date* 26/11/2021					
2.	Reporter(Your) *EastName*					
	CHAN					
3.	Reporter(Your) FirstName*					
	GREGORY					
4.	Reporter (Your) SiteType:*				•	
	Physician ~					
5.	If Other SiteType, please spe	cify:			•	
					roson unitsolonia	
6.	Reporter(Your) Phone#* (only numbers, no -,())				redentes	inaltei .ii
	E 7 16 2					
7.	Immunization Facility	1		THE SHAPE	,	
		Name		SiteType	If other SiteTyp	e, please
	Rexa	II Ponoka	Pharmacy	`	(a	
					weeks (f) and assumed	
8.	Immunization Facility Phone (only numbers, no -,())	#				
9	. Immunizing Facility Address					

City/Town

Building

No/Street/PO

Box

10	. Select Zone: (Click <u>here</u> to determine Central •	zone.)		
11	Patient LastName*			
	Anuszewski			Requiring form
12	Patient FirstName*			
	mistrate distant succession			
13.	If Patient is a minor, then Parent/Guardia	n		
	LastName	FirstName	RelationToPati	
		, - '	-	
14.	Patient Sex at Birth:*			tensfrige; is Vironoss
	F-Female V			
15.	Patient/Guardian Phone#* (only numbers, no -,())			
	103-358-1795			
16.	PHN/ULI Info:			
	867236900			
17.	Date Of Birth(dd/mm/yyyy)*			
18.	Patient Address:			
	Building No/Street/PO	City/Town	Province	PostalCode(A1A 1A1)
	(1, 5116-48 A	PONOKA	AB	T4J 1J2
	Date Of Immunization(dd/mm/yyyy):* 15/10/2021			
20.	Time of Immunization(If Known)(00:00:00:00:00:00:00:00:00:00:00:00:00:	0)		
21.	List all the vaccines given on date of immu Immunization Information:	unization.		
	Vaccine Code		LotNo.	
	COVPRmP >	DDE DIONE		

-- Please Si 🗸

-- Please Si 🗸

Please S₁ ∨	Please St 🗸
- Please S₁ ✓	Please St 🗸
Please Si 🗸	Please St 🗸

Sympt	oms	Started Date (mm/dd/yyyy)	Resolv	ved?	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

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.

Today's Date*
29/11/2021
 Reporter(Your) LastName*
CHAN
 Reporter(Your) FirstName*
GREGORY
 Reporter (Your) SiteType:*
Physician
 If Other SiteType, please specify:
 Reporter(Your) Phone#*
(only numbers, no -,())

Immunization Facility:



If other SiteType, please specify

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

9. Immunizing Facility Address

Building No/Street/PO Box

City/Town

Province

Postalcode(A1A 1A1)

LotNo.

10. Select Zone: (Click Central ✓	<u>here</u> to determine z	one.)		
11. Patient LastName*				
Curie				
12. Patient FirstName*				
Warner Jarvis				
13. If Patient is a minor, the	en Parent/Guardian			
	LastName	FirstName	RelationToPatient	
	-	-	-	
14. Patient Sex at Birth:*				
M-Male 🗸				
15. Patient/Guardian Phone:	#*			
(only numbers, no -,())				
P00-000-2280				
16. PHN/ULI Info:				
614779810				
17. Date Of Birth(dd/mm/yy				
18/04/1963	/y)*			
18. Patient Address:				
10. Fatient Address:				
	Building No/Street/POBox	City/Town	Province	PostalCode(A1A
	BOX 2828	MASKWACIO	Silver of	1A1)
		WAGAWAGG	Ab	TOC INO
19. Date Of Immunization(dd, 18/11/2021	/mm/yyyy):*			
20. Time of Immunization(If k	(nown)(00.00.00)			
00:00:00	(10,00:00:00)			
21. List all the vaccines given	on date of immunize	ation		
Immunization Information	:	acion,		
	Vaccine Code	Manufacturer	LotNo.	

MODTH-Moc **▼**

-- Please Sel ✔

COVMODmF **→**

-- Please Sel 🗸

Please Sel ✔	Please Sel ♥	
Please Sel ✔	Please Sel ➤	
Please Sel ✔	Please Sel ➤	

Sympto	oms	Started Date (mm/dd/yyyy)	Resolv	ed?	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.





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

Today's Date*				
21/12/2021	Alte Authorities			
Reporter(Your) LastName	*			
Chan				
Departmen(Vour) FirstName	o*			
Reporter(Your) FirstName Gregory				
		- Control Control		
Reporter (Your) SiteType	:*			
Physician ~	•			
				647 TEM
If Other SiteType, please	specify:			
				eyey manaayene 10 mmg
Reporter(Your) Phone#* (only numbers, no -,())				
(only hambers, no ,(,))				
			ned a treet the	
Immunization Facility				
	Name	s	iteType	If other SiteType, pleas
			*	specify
	Parson's Pharmacy	Pharmacy	- Y	<u></u>
-8 - 1 - 1 - 1 - 1 - 1				
Immunization Facility Ph (only numbers, no -,())	none#			
(only numbers, no -,())				
		acas		
Immunizing Facility Add	iress			
	Building			Postalcode(A1A

City/Town

No/Street/PO

Box

Province

1A1)

10.	process and the second second	here to determine zo	one.)		
	Central 🗸				
11.	Patient LastName*				
	Fleming				
12.	Patient FirstName*				
	Margo		Japan area		
13.	If Patient is a minor, th	hen Parent/Guardian			
		LastName	FirstName	RelationToPati	ent
		-	-	-	
14	Patient Sex at Birth:*				
- 1.	F-Female				
15.	Patient/Guardian Phon (only numbers, no -,())	e#*			
	403-505-6703				
16.	PHN/ULI Info:				
	533766410				
17.	Date Of Birth(dd/mm/y	/yyy)*			
18	Patient Address:				
10.	ratient Address.	Building			
		No/Street/POB	City/Town	Province	PostalCode(A1A 1A1)
			RIMBEY	(AB)	TOC 2007
	Date Of Immunization(dd/mm/yyyy):*			
	21/06/2021				
20.	Time of Immunization(If Known)(00:00:00)			
	00:00:00				
24	list all M				
21.	List all the vaccines given Immunization Informati	en on date of immuni ion:	zation.		
		Vaccine Code	Manufacturer	LotNo.	
		COVPBmR ✔	BPF-BioNTi ✔	politica	
		Please St 🗸	Please Sı 🗸		

RED DEER

AB

T4N 1T6

1C - 4755 49TH

Please Si 🗸	Please St 🗸
Please Sı 🗸	Please Si 🗸
Please S _t 🗸	Please St 🗸
- Please S₁ ∨	Please S₁ ✓

oms	Started Date (mm/dd/yyyy)	Resolv	red?	(mm/dd/yyyy)
~	07/19/2021	No	v j	
~)		None	v]	
~)		None	~)	
~		None	v]	
	oms	(mm/dd/yyyy) • 07/19/2021 •	(mm/dd/yyyy) V 07/19/2021 No None None	(mm/dd/yyyy) V 07/19/2021 No V None V None V

Pecalyod Date

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

A STATE OF THE PARTY OF THE PAR	
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.*



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.



#30492 Page 1/1

Jan 31, 2022

note AHS AEFI said no contraindications for next vaccine

SG





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.

- Today's Date* 6/1/2022
- Reporter(Your) LastName* CHAN
- Reporter(Your) FirstName* **GREGORY**
- Reporter (Your) SiteType:* Physician
- If Other SiteType, please specify:
- Reporter(Your) Phone#* (only numbers, no -,())
- 7. Immunization Facility:



Ponoka Professional Pharma



If other SiteType, please specify

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



Immunizing Facility Address

Building No/Street/PO Box

City/Town

Province

Postalcode(A1A 1A1)

COVMODmF **▼**

-- Please Sel ✔

LotNo.

	< here to determine z	one.)		
Central 🗸				
11. Patient LastName*				
Surbey				
12. Patient FirstName*				
13. If Patient is a minor, t	hen Parent/Guardian			
	LastName	FirstName	RelationToPatie	
	-		-	Profes of pure joins;
14. Patient Sex at Birth:*				
M-Male 🗸				
15. Patient/Guardian Phon	e#*			
(only numbers, no -,())				
403-588-0597				
16. PHN/ULI Info:				
884162010				
17. Date Of Birth(dd/mm/y	/yyy)*			
21-10-1951				
18. Patient Address:				
	Building No/Street/POBo	City/Town	Province	PostalCode(A1A
	6822-61 STREE	PONOKA	AR INVE	1A1)
		processes for a	The Manager of Alexander	THE COLUMN
19. Date Of Immunization(c 23/12/2021	dd/mm/yyyy):*			
20. Time of Immunization(I	f Known)(00:00:00)			
00:00:00				
21. List all the vaccines give Immunization Information	en on date of immuniz	zation.		
A) A labeatisased	Vaccine Code	Manufacturer	LotNo.	

MODTH-Moc **▼**

-- Please Sel ✔

Please Sel ➤	Please Sel ➤	
Please Sel ➤	Please Sel ➤	
Please Sel ✔	Please Sel ➤	

Sympto	oms	Started Date (mm/dd/yyyy)	Resolv	ed?	Resolved Date (mm/dd/yyyy)
Pain and/o	r 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.

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.

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:

kionsberg, Jan 31, 2022, 3:44PM

Page 1/1 Birth date #15908

Feb 8, 2022

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: Canny Skionsberg, Feb 8, 2022, 11:12AM

Feb 10, 2022

GC

PS

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





Note: This form is for health care practitioner use only. If you are a member of the general public and need to 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 Reporter(Your) FirstName* Gregory Reporter (Your) SiteType:* Physician If Other SiteType, please specify: Reporter(Your) Phone#* (only numbers, no -,()) 7. Immunization Facility: If other SiteType, please SiteType Name specify Ponoka Shoppers Drug Mart Pharmacy

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



Immunizing Facility Address

Building No/Street/PO Box

City/Town

Province

10.	Select Zone: (Click <u>here</u> to d	etermine zor	ne.)		
11.	Patient LastName*				
	Lloyd				
12.	Patient FirstName*				
	- Tables in the same				
13.	If Patient is a minor, then Parent	/Guardian			
		.astName	FirstName	RelationToPatien	• Util tribbe
			-	-	
14.	Patient Sex at Birth:*				
	M-Male 🗸				
15.	Patient/Guardian Phone#*				
	(only numbers, no -,())				Charles I washing
1	403-307-8216				
16.	PHN/ULI Info:				
	840141980				
17.	Date Of Birth(dd/mm/yyyy)*				
	06711/1996				
18.	Patient Address:				
		Building	City/Town	Province	PostalCode(A1A
	No/S	treet/POBox	City, Town	Province	1A1)
		BOX 8 SITE	PONOKA	AB	T4J 1R3 Justicul nend
19.	Date Of Immunization(dd/mm/yy	/yy):*			
	17/11/2021				
20.	Time of Immunization(If Known)((00:00:00)			
	00:00:00				
21. l	ist all the vaccines given on date immunization Information:	e of immuniza	ation.		
	Vacc	ine Code	Manufacturer	LotNo.	
	COVE	PBmR 🗸	BPF-BioNT₁ ✓	ordation.	
		ase Si 🗸	Please Si V		

- Please S₁ ✓ - Please S₁ ✓
- Please S₁ ✓ - Please S₁ ✓
- Please S₁ ✓ - Please S₁ ✓

22. Adverse Event Info:

Sympt	oms	Started Date (mm/dd/yyyy)	Resolv	ved?	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.

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.





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.

Today's Date*
 17/1/2022
 Reporter(Your) LastName*
 CHAN
 Reporter(Your) FirstName*
 GREGORY
 Reporter (Your) SiteType:*
 Physician ▼
 If Other SiteType, please specify:
 Reporter(Your) Phone#*
 (only numbers, no -,())

7. Immunization Facility:



If other SiteType, please specify

8. Immunization Facility Phone#

(only numbers, no -,())



Immunizing Facility Address

Building No/Street/PO Box

City/Town

Province

14. Patient Sex at Birth:*

M-Male

✓

15. Patient/Guardian Phone#*
(only numbers, no -,())
403-/04-5351

16. PHN/ULI Info:



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



18. Patient Address:

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

 Date Of Immunization(dd/mm/yyyy):* 28/09/2021

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 ✔	

Sympt	oms	Started Date (mm/dd/yyyy)	Resolv	red?	Resolved Date (mm/dd/yyyy)
Other	~	10/14/2021	No	~	
None	~		None	~	N
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.

Birth date 8/01/1989 #8236 Page 1/1

Feb 7, 2022

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: Feb 7, 2022, 9:43AM

Feb 8, 2022

GC

PS

Dr. Gregory Chan, February 8, 2022, 11:52AM

** COVID-19 telephone conversation **

discussed AEFI with

wanting to clarify, but I simply REITERATED the previous information on the submitted form Dr. Gregory Chan, February 8, 2022, 11:52AM





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.

	adverse event following immuniz	ation, please can rical	Cit Ellik de Gaa of as		
<u> </u>	T. J. J. Datas				
1.	Today's Date*				
	19/1/2022				
2.	Reporter(Your) LastName*				
	Chan				
3.	Reporter(Your) FirstName*				
	Gregory				(Characteristical April)
4.	Reporter (Your) SiteType:*				
	Physician				patest partyrens
5.	If Other SiteType, please spe	cify:			Variable Marian
					weAgrerlands Unid 10 stact .
6.	Reporter(Your) Phone#*				
	(only numbers, no -,())				
	403-783-3399				
7.	Immunization Facility				
		Name	Site	еТуре	If other SiteType, please specify
	Phar	masave Clive	Pharmacy	~	
	I	#			

- Immunization Facility Phone# (only numbers, no -,())
 403-784-0421
- 9. Immunizing Facility Address

Building No/Street/PO Box

City/Town

Province

1	0. Select Zone: (Click <u>h</u> Central ∨	<u>ere</u> to determine zone	.)		
1	1. Patient LastName*				
	Van Eaton				
12	2. Patient FirstName*				
	Stephanie 350%				
13	3. If Patient is a minor, the				
		LastName	FirstName	RelationToP	atient
14	. Patient Sex at Birth:*				standing that refresh
	F-Female V				
15	. Patient/Guardian Phone#				
13	(only numbers, no -,())	*			
	403-550-4085				
16	PHN/ULI Info:				
10.	579816051				
17.	Date Of Birth(dd/mm/yy	yy)*			and the first
10	Patient Address:				
10.	Patient Address:	Building			(1.5 of Jestenius And
		No/Street/POBox	City/Town	Province	PostalCode(A1A 1A1)
		BOX 449	CLIVE	AB	TOC 0Y0 DOES INCHIES
	Date Of Immunization(dd	l/mm/yyyy):*			
20.	Time of Immunization(If	Known)(00:00:00)			
	00:00:00				
21.	List all the vaccines given Immunization Information	on date of immunizati	ion.		
		Vaccine Code	Manufacturer	LotNo.	
		COVPBmR V	BPF-BioNT₁ ✓	FF2595	

-- Please St V

-- Please Si 🗸

Please S₁ ✔	Please S₁ ∨
Please S₁ ✓	Please S₁ ✔
Please S₁ ✓	Please Si 🗸

Sympt	oms	Started Date (mm/dd/yyyy)	Resolv	ed?	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.*

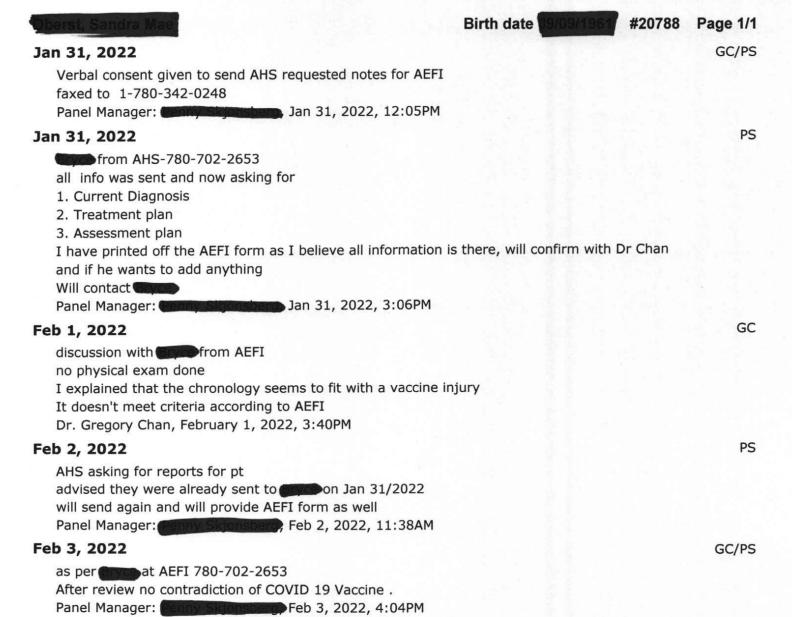
Yes 🗸

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

Yes 🗸

Note: Hit Done button to Submit the Form.

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.







Postalcode(A1A

1A1)

Province

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.

	adverse event following immu	nization, please call H	lealth Link at 811 or c	ontact your healt	h provider.
					D. If Rebert is a micro program
1.	Today's Date*				
	19/1/2022				
2.	Reporter(Your) LastName*				
	Chan				
3.	Reporter(Your) FirstName*				
	Gregory				
		*			Control of the Contro
4.	Reporter (Your) SiteType:*				
	Physician ~				
5.	If Other SiteType, please sp	ecify:			Complete of the Complete of th
	ve.				
					Question 1
6.	Reporter(Your) Phone#*				Control Authority 61
	(only numbers, no -,())				
	1000				
7.	Immunization Facility:		A STATE OF THE STA	WALL STREET,	
			Si	teType	If other SiteType, please
		Name	31	terype	specify
	Re	xall Ponoka	Pharmacy	~	
8.	Immunization Facility Phon	e#			
	(only numbers, no -,())				
Ħ					
9	. Immunizing Facility Addre	SS			

City/Town

Building

No/Street/PO

Box

10	. Select Zone: (Click <u>here</u> to determine zone	.)		
	Central 🗸			
11	. Patient LastName*			
	Oberst			
12	. Patient FirstName*			
	Sandra - stebies in others may research			
13	. If Patient is a minor, then Parent/Guardian			
	LastName	FirstName	RelationToPatien	1
		•	-	
14.	Patient Sex at Birth:*			
	F-Female V			
15.	Patient/Guardian Phone#*			
	(only numbers, no -,())			
	103-783-0485			
16.	PHN/ULI Info:			handayia
	942641030			
17.	Date Of Birth(dd/mm/yyyy)*			
18.	Patient Address:			
	Building No/Street/POBox	City/Town	Province	PostalCode(A1A
	6412-51 STREE	PONOKA I	AB	1A1) T4J1E2
	Date Of Immunization(dd/mm/yyyy):*		- TRAVELEY	
13.	02/40/0004			
20.	Time of Immunization(If Known)(00:00:00)			
	00:00:00			
21.	List all the vaccines given on date of immunizat Immunization Information:	ion.		
	Vaccine Code	Manufacturer	LotNo.	

BPF-BioNT₁ ✓

-- Please Si 🗸

COVPBmR ✓

-- Please St >

Please S₁ ∨	Please St 🗸
Please S₁ ✓	Please St 🗸
Please Si 🗸	Please Si 🗸

Sympt	oms	Started Date (mm/dd/yyyy)	Resolv	red?	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.

Page 1/1 Birth date #13459

Feb 17, 2022

BRYCE AEFI

appt has been made to speak with Dr Chan

Feb 17, 2022, 3:51PM Panel Manager:

Feb 18, 2022

GC

GC/PS

Dr. Gregory Chan, February 18, 2022, 9:52AM

discussion with AEFI

discussed Historical/Forensic Science vs Observation/Experimental Science

Dr. Gregory Chan, February 18, 2022, 9:56AM





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.

- Today's Date*
 11/2/2022
- Reporter(Your) LastName* CHAN
- Reporter(Your) FirstName* GREGORY
- Reporter (Your) SiteType:*
 Physician
- 5. If Other SiteType, please specify:
- Reporter(Your) Phone#* (only numbers, no -,())







Name

SiteType

If other SiteType, please specify

Ponoka Professional Pharma

Pharmacy

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



9. Immunizing Facility Address

Building No/Street/PO Box

City/Town

Province

10.	Select Zone: (Click <u>here</u> to determine zon	ee.)		
11.	Patient LastName*			
	A to Faller			
12.	Patient FirstName*			
	Theresa			
13.	If Patient is a minor, then Parent/Guardian			
	LastName	FirstName	RelationToPati	ent
			-	
14	Dakinah Carras Buru			
14.	Patient Sex at Birth:* F-Female			
15.	Patient/Guardian Phone#* (only numbers, no -,())			
	Company of the Compan			
16.	PHN/ULI Info: 787559120			
17.	Date Of Birth(dd/mm/yyyy)*			
10	04/06/1964 P			Report of Test Prince?
18.	Patient Address: Building			PostalCode(A1A
	No/Street/POBox	City/Town PONOKA	AB	1A1) T4J 1R1
	Date Of Immunization(dd/mm/yyyy):* 07/01/2022	yoursen's appoint		
20.	Time of Immunization(If Known)(00:00:00) 00:00:00			
	List all the vaccines given on date of immuniz Immunization Information:	ration.		
	Vaccine Code COVMO ✓	Manufacturer MODTH- 🗸	LotNo.	

-- Please 🗸

Pleas€	~	Pleas€	~
Pleas∈	~	Please	V
Pleas€	~	Please	V

Sympton	ns	Started Date (mm/dd/yyyy)	Resol	lved?	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.

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.

GC/PS

Feb 22, 2022

AEFI 587-782-4345

"pt can go ahead with future vaccines for MRNA/Covid"

noet to Dr Chan

Panel Manager:

Feb 22, 2022, 11:33AM





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 Reporter(Your) FirstName* **GREGORY** 4. Reporter (Your) SiteType:* Physician 5. If Other SiteType, please specify: Reporter(Your) Phone#* (only numbers, no -,()) 7. Immunization Facility: If other SiteType, please SiteType Name specify No Frills Pharmacy

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



9. Immunizing Facility Address

Building No/Street/PO Box

City/Town

Province

10. Select Zone: (Click <u>here</u> 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:*

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)
T4J 1R4

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 ✓

Pleas€	V	Pleas€	V
Pleas€	~	Please	V
Please	~	Pleas€	V

Symp	toms	Started Date (mm/dd/yyyy)	Reso	lved?	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.





1.

2.

3.

4.

5.

6.

7.

8.

Page 1 of 1

Note: This form is for health care practitioner use only. If you are a me adverse event following immunization, please call Health Link at 811 or	mber of the general public and need to report an recontact your health provider.
Today's Date* 17/4/2022	
Reporter(Your) LastName*	
Onan	
Reporter(Your) FirstName*	
Gregory	
Reporter (Your) SiteType:*	
AHS Acute Care ▼	
If Other SiteType, please specify:	
Reporter(Your) Phone#*	
(only numbers, no -,())	
Immunization Facility:	
	If other SiteType, please specify
Immunization Facility Phone#	
(only numbers, no -,())	

Immunizing Facility Address

Building No/Street/PO Box

City/Town

Province

10.	Select Zone: (Click <u>her</u> Central ✓	<u>e</u> to determine zone.)			
11.	Patient LastName*				
12.	Patient FirstName*				
13.	If Patient is a minor, then	Parent/Guardian LastName	FirstName	Polation To Pation A	1 Posterio
		-	-	RelationToPatient	1997
14.	Patient Sex at Birth:* M-Male ✓				
15.	Patient/Guardian Phone#* (only numbers, no -,())				
16.	PHN/ULI Info: 482304720				
17.	Date Of Birth(dd/mm/yyyy	/)*			
18.	Patient Address:				
		Building No/Street/POBox 6102-51 STREET	City/Town	Province	PostalCode(A1A 1A1) T4J 1E7
19.	Date Of Immunization(dd/	mm/yyyy):*			

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 ❤	

Sympto	oms	Started Date (mm/dd/yyyy)	Resolv	ed?	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.

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.



1.

2.

3.

4.

5.

6.

7.

8.

Page 1 of 1

Note: This form is for health care practitioner use only. I adverse event following immunization, please call Health	
Today's Date* 24/5/2022	
Reporter(Your) LastName* CHAN	
Reporter(Your) FirstName* GREGORY	
Reporter (Your) SiteType:*	
Physician	Lile on Results Survive
If Other SiteType, please specify:	
Papartar(Vaur) Phana#*	
Reporter(Your) Phone#* (only numbers, no -,())	
Immunization Facility:	
Name Maskwacis Health Services	SiteType If other SiteType, please specify First Nations and Inuit He: ▼
Immunization Facility Phone# (only numbers, no -,())	
780-585-3830	

9. Immunizing Facility Address

Building No/Street/PO Box

City/Town

Province

10	. Select Zone: (Click he Central ❖	<u>re</u> to determine zone.)			
11.	Patient LastName*				
	WOLFE 1				
12.	Patient FirstName*				
	CHRISTINA				
13.	If Patient is a minor, then	Parent/Guardian			
		LastName	FirstName	RelationToPatient	
14.	Patient Sex at Birth:*				
	F-Female				
15	Patient/Cuardian Bhana#				
15.	Patient/Guardian Phone# (only numbers, no -,())	*			
	587-729-0145				
16.	PHN/ULI Info:				
	427614310				
17.	Date Of Birth(dd/mm/yyy	y)*			
'	20/03/1956				
18.	Patient Address:				
		Building No/Street/POBox	City/Town	Province	PostalCode(A1A
		5210-49 AVE	PONOKA	(ARIO)	1A1)
		THE DESCRIPTION OF STREET	- 100	A Programme	
19.	Date Of Immunization(dd/ 11/05/2021	/mm/yyyy):*			
20.	Time of Immunization(If K	(nown)(00:00:00)			
	00:00:00				
21.	List all the vaccines given	on date of immunizatio	n.		

Manufacturer LotNo. COVMODmF **▼** MODTH-Moc **▼** -- Please Sel > -- Please Sel 🗸

Vaccine Code

Immunization Information:

Please Sel ✔	Please Sel ✔	
Please Sel ✔	Please Sel ✔	
Please Sel ➤	Please Sel ➤	

Sympt	oms	Started Date (mm/dd/yyyy)	Resolv	red?	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.

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.

Birth date 8/06/1948 #39674 Page 1/1

Sep 19, 2022

GC

discussed with 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

9. Immunizing Facility Address

Building No/Street/PO Box

City/Town

Province

Postalcode(A1A 1A1)



	ı	
	Sasianos	Miner of Linear

		AEFI Reporting Form
Nos		7
erse		Re
eve		20
7 1		5
s for		77
ing i		07
1		3
are		
prac		
titio		
ner		
call		
Hea		
14		
ink a		
83		
1 01		
con		
tact		
you you		
ene:		
# P		
ublic		
Note: This form is for health care practitioner use only. If you are a member of the general public and adverse event following immunization, please call Health Link at 811 or contact your health provider.		
200		
6	100	
repo	Page	
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.	Page 1 of	
	-	

μ		2.		
3. Reporter(Your) FirstName*	CHAN	Reporter(Your) LastName	and the first owner.	1. Today's Date
	ter organis de manuel families and appearance and a			

5		4.	
If Other SiteType, please specify	Physician	Reporter (Your) SiteType:*	
	C		

	6	
(only numbers, no -,())	Reporter(Your) Phone#*	man in the contract of the con
		Company of the Company

Shappers Drug N	Ner	Immunization Facility:
art Pharmacy	e SiteType	
0	_	
	If other SiteType, please specify	

ç	(only numbers, no -,())
	And the property of the second section of the section o

https://survey.albertahealthservices.ca/TakeSurvey.aspx?SurveyID=mIK33n321#

9.		
Immunization Facility Phone#	pers Drug	
	Pharmacy	
	200	•
		s Drug Mart Pharmacy

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

18.	17.	16.	5	4.	13.	12.	_ =	15	
18. Patient Address:	17. Date Of Birth(dd/mm/yyyy)=	16. PHN/ULI Info:	Patient/Guardian Phone#* (only numbers, no -,())	14. Patient Sex at Birth:* F-Female	If Patient is a minor, then Parent/Guardian LastName	12. Patient FirstName	11. Patient LastName*	10. Select Zone: (Click E	
	=-(AAA)=		***		en Parent/Guardian LastName	And the second s		(Click here to determine zone.)	5015-50 STREET
			and the second s		FirstName			E,	PONOKA
					RelationToPatient				AB
									T4J 0C1

Alberta Health Services (AHS). The pects your anfile straility and privacy, nour information anoliected, 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

Note: Hit Done button to Submit the Form.

health services, conducting research, providing for health services, provider education, internal management public health surveillance and health system management, public health surveillance and health is primarily for: providing health services, determining eligibility for health services, processing payments for

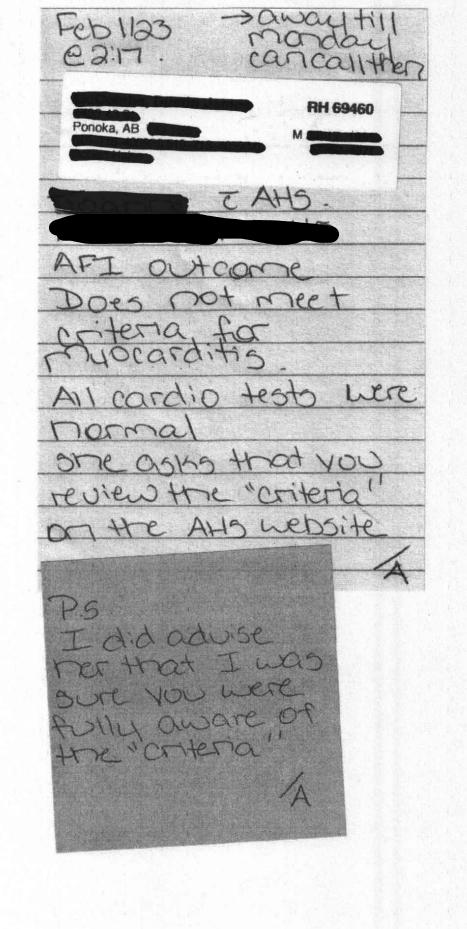
policy development.

のながの

Done

	25. Patient		with mi	24. Additio	bruising	23. If other						22. Advers								21. List all Immur		20. Time o	23/12/2021	19. Date C
Services AEFI follow-up.	is aware that you		about 2 weeks after booster injection with minimal trauma not present prior to booster injection	Additional Information:	bruising, ecchymosis	, describe includin	None	None	None	Rash		Adverse Event Info:								List all the vaccines given o Immunization Information:	5	f Immunization(If	021	Date Of Immunization(dd/mm/yyyy):
	are reporting the A	and the second s	about Z weeks after booster injection - brusing and eccnymosis with minimal trauma on the properties of the booster injection of present prior to booster injection.		and the same of th	If other, describe including Started date & Resolved date:	@	0	6	©	Symptoms		- Predate out) (Planca Spl.	Please Seli 🖨	Please Seli 😝	COVPBMRNA	Vaccine Code	List all the vaccines given on date of immunization. Immunization Information:	The second second	Time of Immunization(If Known)(00:00:00)	No.	/mm/yyyy):-
	Patient is aware that you are reporting the AEFI description and patient contact information to Alberta Health	to common or one confined on the consideration to property	d ecchymosis			esolved date:		A THE RESERVE AND THE PERSON AND THE	A CONTRACTOR OF THE PERSON NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN COLUMN TWO IS NAMED IN COLUMN T	01/10/2022	Started Date (mm/dd/yyyy)		The voc seeds		Plagse Seli	Please Sek 😘	Please Seli 👸	BPF-BigNTec	Manufacturer	ization.				
patient contact							None	None	None	No	Resolved?			A magest a settle of the second			***************************************	28-227-DK	LotNo.					
	information	A second					0	0	0	0	ed?		-	11			-	1						
	to Alberta Health								And the second s	And the state of the same of t	Resolved Date (mm/dd/yyyy)													

Page 3 of 4





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.

- Today's Date* 30/12/2022
- Reporter(Your) LastName* CHAN
- Reporter(Your) FirstName* Gregory
- Reporter (Your) SiteType:*
 AHS Acute Care
- 5. If Other SiteType, please specify:
- Reporter(Your) Phone#*
 (only numbers, no -,())

7. Immunization Facility:

Name Rexall Ponoka SiteType
Pharmacy

If other SiteType, please specify

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



9. Immunizing Facility Address

Building No/Street/PO Box

City/Town

Province

Postalcode(A1A 1A1)

	Central • Patient LastName*	e to determine zone.)			
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: 879624071				
	Date Of Birth(dd/mm/yy)	/y)*			
	Patient Address:	Building No/Street/POBox	City/Town	Province	PostalCode(A1A 1A1) T4J 1B8
19.	Date Of Immunization(do 22/10/21	d/mm/yyyy):*			
20.	Time of Immunization(If 00:00:00	Known)(00:00:00)			

Vaccine Code Manufacturer

COVPBmRN ♥ BPF-BioNTe(♥

-- Please Sel ♥ -- Please Sel ♥

LotNo.

21. List all the vaccines given on date of immunization.

Immunization Information:

Please Sel ✔	Please Sel ➤
Please Sel ✔	Please Sel ✔
Please Sel ➤	Please Sel ✔

Sympt	oms	Started Date (mm/dd/yyyy)	Resolv	ed?	Resolved Date (mm/dd/yyyy)
Pain and/o	r Swe 🕶	10/24/2021	No	~	
Other	~	10/24/2021	No	~	
None	~		None	~	
None	~		None	~	

 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.

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





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

Today's Date*				
17/1/2023	Jestavi of mutated			
Reporter(Your) LastName	e*			
CHAN				
Reporter(Your) FirstNam	e*			
GREGORY				
Reporter (Your) SiteType	*			
Physician	~			
If Other SiteType, please	specify:	_		
Reporter(Your) Phone#* (only numbers, no -,())				
(only numbers, no -,(y)		-		
Immunization Facility		1		
Immunization Facility	Name	S	iteТуре	If other SiteType, please specify
(F	Pharmacy	Pharmacy	~	unknown
Immunization Facility Pho (only numbers, no -,())	one#			
		and the		
Immunizing Facility Addr	recc			
Inmanizing racinty Addi	Building			

10.	Select Zone: (Click <u>here</u>	e to determine zone.)		
11.	Patient LastName*				
12.	Patient FirstName*	k mong tali in sanah			
13.	If Patient is a minor, then	Parent/Guardian	FirstName	RelationToPatient	
		-	-	1 (-	
14.	Patient Sex at Birth:* F-Female				
15.	Patient/Guardian Phone# (only numbers, no -,()) 403-318-1389	*			
16.	PHN/ULI Info:				
17.	Date Of Birth(dd/mm/yyy	(y)*			
	Patient Address:	Building No/Street/POBox	City/Town	Province	PostalCode(A1A 1A1)
30	Date Of Immunization(do	l/mm/yyyy):*			
20.	Time of Immunization(If 00:00:00	Known)(00:00:00)			
21.	List all the vaccines giver Immunization Informatio		ation.		
		Vaccine Code	Manufacturer	LotNo.	
		COVMODm ✔	MODTH-Ma ✔	807 108	

-- Please Se ➤

-- Please Se ✔

PONOKA

AB

Please Se ✔	Please Se ✔	
Please Se 🗸	Please Se 🗸	
Please Se ✔	Please Se ✔	

Symptoms	Started Date (mm/dd/yyyy)	Resolve	ed?	Resolved Date (mm/dd/yyyy)
Pain and/or Sw∈ ✓	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.*

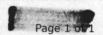
Yes 🕶

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





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.

Today's Date*		
10/2/2023		
Reporter(Your) LastName*		
CHAN		
Reporter(Your) FirstName*		
GREGORY		
Reporter (Your) SiteType:*		
Physician		
f Other SiteType, please specify:		
Reporter(Your) Phone#* only numbers, no -,())		Many responsibilities and
stricke Sestanti	priofe6 www.tya.tz taeviiteit	
mmunization Facility:	SiteType	If other SiteType, please specify
UNKNOWN	Please Select	
mmunization Facility Phone#		
only numbers, no -,())		

City/Town

Building

No/Street/PO

Box

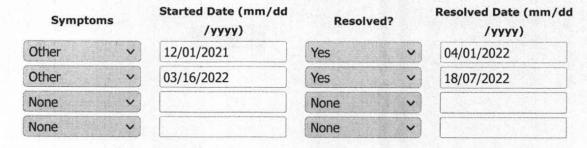
Postalcode(A1A

1A1)

Province

		-	-	- 4 4	
10. 5	OCCUPATION OF THE PROPERTY OF	to determine zone	2.)		
	Central V				
11.	Patient LastName*				
	LABRECQUE				
12.					
	OENIS CODIV	uniq pictenti rasiy Yintin	CE SU LE LE XIMI (1786		
13.	If Patient is a minor, then	Parent/Guardian			1182/2023
		LastName	FirstName	RelationToPatier	it .
		-	-] -	
14.	Patient Sex at Birth:*				
	M-Male ~				
15.	Patient/Guardian Phone#*				
	(only numbers, no -,())				
	H03-896-7225				
16.	PHN/ULI Info:				
	©93084600 P				
17.	Date Of Birth(dd/mm/yyy	y)*			
	24/04/1974				
10	Patient Address:				
10.	ratient Address.	Destilation of			
		Building No/Street	City/Town	Province	PostalCode(A1A
		/POBox			1A1)
		GOX 67 SITE 10	PONOKA	AB	T4) 1R3
10	Date Of Immunization(dd	//mm/vvvv):*			
19.	13/11/2021]			
		J (20 00 00)			
20.	Time of Immunization(If	Known)(00:00:00)			
	00:00:00				
21.	List all the vaccines given		ization.		
	Immunization Information			lsurfdug.	
		Vaccine Code	Manufacturer	LotNo.	
		COVPBmRN# ~	BPF-BioNTec ∨	207	

Please Sel >	Please Sel V	
Please Sel >	Please Sel V	
Please Sel >	Please Sel >	240 (BESTY 11 11 11 11 11 11 11 11 11 11 11 11 11
Please Sel >	Please Sel >	



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.*

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

Note: Hit Done button to Submit the Form.

Application of the least total

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

and her in telegroups to the policy of the policy of the company that is described





Page 1 of 1

	MAN TO THE RESERVE OF THE PARTY	A STATE OF THE STA
	Note: This form is for health care practitioner use only. If you are a member	er of the general public and need to report an
	adverse event following immunization, please call Health Link at 811 or co	ntact your health provider.
	Todoulo Debas	
1.		
	14/11/2021	
2.	Reporter(Your) LastName*	
	CHAN	
3.	Reporter(Your) FirstName*	
	GREGORY	
4.	Reporter (Your) SiteType:*	
	Physician •	The state of the s
5.	If Other SiteType, please specify:	
		() = 11 × 12 × 13 × 14 × 15 × 14 × 15 × 14 × 15 × 14 × 15 × 14 × 15 × 14 × 15 × 14 × 15 × 14 × 15 × 14 × 15 × 14 × 15 × 14 × 14
6.	Reporter(Your) Phone#*	
0.	(only numbers, no -,())	
		W The Market
7	Immunisation Facility	
7.	Immunization Facility:	
	Name SiteTy	pe If other SiteType, please
	Poets & Rewise Pharman	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)

00:00:00

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

Vaccine Code	Manufacturer	LotNo.	
COVPBmRN ▽	BPF-BioNTer ➤		
Please Sel ➤	Please Sel ➤		

Please Sel ✔	Please Sel ✔	
Please Sel ✔	Please Sel ➤	
Please Sel ✔	Please Sel ✔	

Symptoms Severe Diarrhea >		Started Date (mm/dd/yyyy) 11/06/2021	Resolved?		Resolved Date (mm/dd/yyyy)
			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.

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