



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

- 1. Today's Date* 13/10/2021
- 2. Reporter(Your) LastName* CHAN
- 3. Reporter(Your) FirstName* Gregory
- 4. Reporter (Your) SiteType:* Physician
- 5. If Other SiteType, please specify:
- 6. Reporter(Your) Phone#* (only numbers, no -,())









Name

SiteType

If other SiteType, please specify

East Central Health/Camrose Public Health



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



9. Immunizing Facility Address

Building No/Street/PO Box

City/Town

Province

CAMROSE

AB

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10.	Select Zone: (Click he	<u>re</u> to determine zone.	.)		
	Central V				
11.	Patient LastName*				
	OE VRIES				
12.	Patient FirstName*				
	MATTY				
13.	If Patient is a minor, ther	n Parent/Guardian			
	ones un transference de la company de la	LastName	FirstName	RelationToPatient	
		-	*	*	
14.	Patient Sex at Birth:* F-Female				
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	Patient/Guardian Phone#	* *			
	403-505-0332				
16	DUN/III T T=50.				
10.	PHN/ULI Info:				
17.	Date Of Birth(dd/mm/yy	уу)*			
	06/10/1989				
18.	Patient Address:				PostalCode(A1A
		Building No/Street/POBox	City/Town	Province	PostalCode(A1A 1A1)
			DONALDA	AB	T0B 1H0
19.	Date Of Immunization(d 12/07/2021				
20.	Time of Immunization(If 00:00:00	F Known)(00:00:00)			
21.	List all the vaccines give		ation.		
		Vaccine Code	Manufacturer	LotNo.	
		COVPBmR 🗸	BPF-BioNT₁ ✓		

-- Please St V

-- Please St V

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

Symptoms		Started Date (mm/dd/yyyy)	Resolv	ed?	Resolved Date (mm/dd/yyyy)
Other	~	09/11/2021	No	~	
None	~		None	~	
None	~		None	~	
None	~		None	~	

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

fetal demise

24. Additional Information:

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

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

No 🗸

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

No V

Note: Hit Done button to Submit the Form.

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





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1.	Today's Date*				
	19/10/2021				
			4-14	**	
2.	Reporter(Your) LastName*				
	CHAN				
2	Reporter(Your) FirstName*				
3.					
	GREGORY				
					公 士 公司 [12]
4.	Reporter (Your) SiteType:*				
	Physician ~				
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5.	If Other SiteType, please sp	ecify:			
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					THE CHAPTER
6.	Reporter(Your) Phone#*				
	(only numbers, no -,())				
		6.W/ 100			
7.	Immunization Facility:	41.000		THE RESERVED OF	
				SiteType	If other SiteType, please
		Name		SiteType	specify
	Por	noka Professional Ph	narma Pharma	cy 🗸	

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

Building No/Street/PO Box

City/Town

Province

AB

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 Inchelle	RelationToPatient Mother	12770148
14.	Patient Sex at Birth:*			
	M-Male V			
15.	Patient/Guardian Phone#* (only numbers, no -,())			
	DUNGUETE			
16.	PHN/ULI Info:			
17.	Date Of Birth(dd/mm/yyyy)*			
18.	Patient Address:			
	Building No/Street/POBox	City/Town	Province	PostalCode(A1A 1A1)
	Date Of Immunization(dd/mm/yyyy):* 06/10/2021			
20.	Time of Immunization(If Known)(00:00:00)			
	00:00:00			
	List all the vaccines given on date of immunization Immunization Information:	n.		

Manufacturer

MODTH-Mc ✓

-- Please St 🗸

LotNo.

Vaccine Code

COVMODr >

-- Please St 🗸

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Please Si 🗸	Please Si 🗸

Symptoms		Started Date (mm/dd/yyyy)	Resolved?		Resolved Date (mm/dd/yyyy)
Rash	~	10/06/2021	No	~	
Other	~	10/16/2021	Yes	~	10/18/2021
None	~		None	~	
None	~		None	~	

23. If other, describe including Started date & Resolved date: tested positive for COVID

24. Additional Information:

OTHER reaction - had 1st injection of MODERNA Oct 6/21 prevalence testing due to 'outbreak' at school - tested positive with RAPID test @ Shoppers Drug Mart Oct 13/21. Symptoms of COVID onset Oct 16/21 - sore throat runny nose. Resolved as of Oct 18/21.

RASH - immediate red raised rash at injection site, resolved with oral antihistamines but

has recurred today October 19, 2021.

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

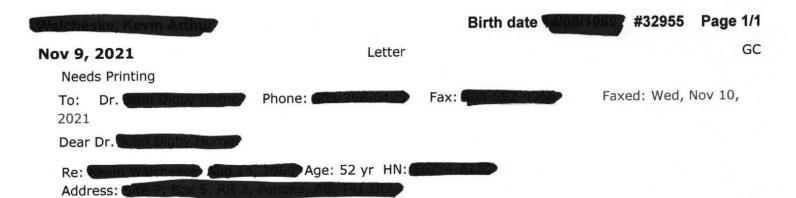
Yes

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

Yes 💙

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

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

Nov 10, 2021

Phone:

GC/PS

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

Dr. Gregory Chan, November 10, 2021, 4:05PM

Mobile:

Business:



Page 1 of 1

	ote: This form is for health care practitioner use on	lv. If you are a	member of the	e general pu	blic and need	to report an ac	lverse event
f	ote: This form is for health care practition as a sillowing immunization, please call Health Link at 81	1 or contact yo	ur health prov	ilder.		4 000	and the second second second
1.	Today's Date						
-	21/10/2021		3			464	4400
2.	Reporter(Your) LastName						
	Chan				¥	433	HEEL.
3.	Reporter(Your) FirstName* Gregory						
4.	Reporter (Your) SiteType:	-120 (8	4.498	413 500	米市报		
	Physician						
	**						
5.	If Other SiteType, please specify:						
	₽ 4						
6.	Reporter(Your) Phone#* (only numbers, no -,()) 403-783-3399						
7.	Immunization Facility:						water toward
	Name		Si	iteType		If other Site'	
	unknown		Pharmacy				
8.	Immunization Facility Phone# (only numbers, no -,())						
9.	Immunizing Facility Address Building						
	No/Street/PO Box	City/Town	n Pi	rovince	Postalco 1A	Annual Control of the	
10.	Select Zone: (Click here to determine zone.) Central)					
11.	Patient LastName*						
12.	Patient FirstName*						

Symptoms		Started Date (mm/dd/yyyy)	Resolved?		Resolved Date (mm/dd/yyyy)
Other	~	09/10/2021	No	~	
Other	v	09/30/2021	No	~	
None			None		
None	•	The second second second	None	~)

- If other, describe including Started date & Resolved date:
 Malaise, cough, night sweats. Leukocytosis.
- 24. Additional Information:

This patient was immunized for COVID on Sep 10/21. He felt unwell, a heaviness in his chest after immunization (Sep 10 or a few days after according to the patient), was asymptomatic prior to immunization.

examined at the ER when the symptoms did not resolve Oct 8/21. Had elevated WBC (13) and neutrophil count (9.5). ECG normal. Diagnosed with anxiety and discharged. These symptoms have not resolved completely, and progressed (see below).

Progressive symptoms for 3 weeks (onset Sept 30/21)- night sweats, malaise, weakness, cough.

Presented to hospital Oct 20/21 with fever and cough. Chest x-ray normal. WBC 33.2 and Neutrophil 31.9. Low lymphocyte count 0.7. Slight elevation of D-dimer 0.12, 0.15. CRP 49, 116. Blood cultures drawn. COVID PCR testing negative (ID NOW and RAPID NAT)

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

Yes

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

Ye:

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1.	Today's Date*						
	22/10/2021						
_	D (V) 1 tN tN						
2.	Reporter(Your) LastNan	ne*					
	CHAN						
3.	Reporter(Your) FirstNar	ne*					
	Gregory						
	5					Committee and the second	
4.	Reporter (Your) SiteTyp	e:*					
	Physician	~					
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5.	If Other SiteType, pleas	e specify:					
6.	Reporter(Your) Phone#	*				Since Selections	
0.	(only numbers, no -,())						
	403-783-3399						
	403-703-3333						
7.	Immunization Facility.		The state of the s				
		Name		SiteType		If other SiteType, please	
		Name		one.,pc		specify	
		Ponoka Professional P	harma Pharma	acy	~		

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

9. Immunizing Facility Address

Building No/Street/PO Box

City/Town

Province

19. Date Of Immunization(dd/mm/yyyy):* 06/10/2021

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

00:00:00

Central

F-Female

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

> **Vaccine Code** Manufacturer LotNo. COVMODr > MODTH-Mc > -- Please Si V -- Please St V

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

Symptoms		Started Date (mm/dd/yyyy)	Resolv	red?	Resolved Date (mm/dd/yyyy)
Other	~	10/08/2021	No	~	
Other	~	10/20/2021	No	~	
Other	~	10/20/2021	No	~	
None	~		None	~	

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

fatigue, COVID, thrombocytopenia

24. Additional Information:

Vaccine #1 for COVID Oct 6/21. Felt unwell with dizziness Oct 9/21. Positive family contact for COVID (children at school were close contacts), so went for testing on Oct 13/21 and had RAPID test in Shoppers Pharmacy and negative. Symptoms continued to persist and worsen thereafter.

Oct 20/21 phone appt and then sent to Hospital due to severe fatigue. Positive RAPID test at hospital.

Also had thrombocytopenia on labwork.

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

Yes

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

Yes 🗸

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Birth date #3152 Page 1/1

Dec 21, 2021

Dr. Gregory Chan, December 21, 2021, 3:10PM - discussed with rom AEFI answered questions about Raynaud's, auto immune condition

pt had Pfizer injection (booster)

Dr. Gregory Chan, December 21, 2021, 3:17PM

Dec 29, 2021

GC/PS

GC

from AEFI

reported even to AHS can continue with vaccinations for Covid and MRNA note to Dr Chan

Panel Manager: Penny Skjonsberg, Dec 29, 2021, 11:21AM



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Page 1 of 1

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



9. Immunizing Facility Address

Building No/Street/PO Box

Shopper's Drug Mart

City/Town

Pharmacy

Province

 Date Of Immunization(dd/mm/yyyy):* 02/06/2021

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.
COVAUVec 🗸	AZC-AstraZ ✓	
Please Si 🗸	Please Si V	

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

Sympt	oms	Started Date (mm/dd/yyyy)	Resolv	red?	Resolved Date (mm/dd/yyyy)
Other	~	06/16/2021	No	~	
None	~		None	~	
None	~		None	~	
None	~		None	~	

23. If other, describe including Started date & Resolved date: severe colour and temperature change in fingers

24. Additional Information:

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

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

Yes 🗸

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

Yes 🗸

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1.	Today's Date* 2/11/2021				
2.	Reporter(Your) LastName*				
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3.	Reporter(Your) FirstName*				
	GREGORY				
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4.	Reporter (Your) SiteType:*			STATE OF THE STATE	
	Physician ~				
5.	If Other SiteType, please specify:			A STATE OF THE STA	
6.	Reporter(Your) Phone#*			Colored a Management	
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7.	Immunization Facility.	4.346	-		
	Name		SiteType	If other SiteType, please specify	
	Unknown	Please	Select 🗸		
8.	Immunization Facility Phone#				
	(only numbers, no -,())				

9. Immunizing Facility Address

Building No/Street/PO Box

City/Town

Province

			4.			
10.	Select Zone: (Click her	<u>re</u> to determine zone	e.)			
11.	Patient LastName*					
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	the tipper					
12.	Patient FirstName*					
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	(United in					
13.	If Patient is a minor, then	Parent/Guardian				
		LastName	FirstName	Deletie T. P. C.	Tankya Dane	
		-	riistiidiile	RelationToPatient	reported	
				-		
1.4	Patient Sex at Birth:*					
14.	F-Female					
	r-remaie V					
1 5	Patient/Guardian Phone#	_				
15.	(only numbers, no -,())	*				
	(D3-783-8173)					
16.	PHN/ULI Info:					
	172640620					
17.	Date Of Birth(dd/mm/yyy	w)*				
-/.	\$1/08/1948	,,				
10	Dationt Address:					
10.	Patient Address:					
		Building No/Street/POBox	City/Town	Province	PostalCode(A1A 1A1)	
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					Herwould	
	Date Of Immunization(dd	/mm/\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\				
13.	04/10/2021					
20						
20.	Time of Immunization(If I 00:00:00	Known)(00:00:00)				
	00.00.00					
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21.	List all the vaccines given Immunization Information		zation.			
		Vaccine Code	Manufacturer	LotNe		
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Please Si 🗸	Please Si 🗸

Sympto	oms	Started Date (mm/dd/yyyy)	Resolv	red?	Resolved Date (mm/dd/yyyy)
Other	~	10/30/2021	No	~	
None	~		None	~	
None	~		None	~	
None	~		None	~	

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

24. Additional Information:

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

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

No 🗸

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

No 🗸

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	Pag	e 1	of 1	ı

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1.	Today's Date*				
	2/11/2021				
2.	Reporter(Your) LastName*				
۷.	CHAN		9.3		
	CHAN				
3.	Reporter(Your) FirstName*				
	GREGORY				
4.	Reporter (Your) SiteType:*				· · · · · · · · · · · · · · · · · · ·
4.					
	Physician ~				
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5.	If Other SiteType, please specify	y:			
6.	Reporter(Your) Phone#*				Contraction of the Contraction o
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7.	Immunization Facility.	-	THE STATE OF	And second or the second	
		Name	9	Cit Turns	If other SiteType, please
		Name	,	SiteType	specify
	Unknow	/n	Pharmacy	· ·	
	Towns look or 5 - Why Bloom #				
8.	Immunization Facility Phone#				
	(only numbers, no -,())				
9.	Immunizing Facility Address				
		Building			Doctolando/A1A

City/Town

Province

1A1)

No/Street/PO

Box

10.	Select Zone: (Click her	<u>e</u> to determine zone	2.)			
11.	Patient LastName*					
	MAIDMENT TO I TO					
12.	Patient FirstName*					
	VICE II I I I I I					
13.	If Patient is a minor, then	Parent/Guardian				
		LastName	FirstName	RelationToPatie	nt ISSUALS	
		- 1	-	-		
14.	Patient Sex at Birth:*					
	F-Female V					
15.	Patient/Guardian Phone#* (only numbers, no -,())	k				
	(Only Humbers, 110 -,())					
16.	PHN/ULI Info:					
	211733800					
17.	Date Of Birth(dd/mm/yyy	y)*				
	16/08/1922					
18.	Patient Address:					
		Building	City /Taxas	Province	PostalCode(A1A	
		No/Street/POBox	City/Town	Province	1A1)	
		RIMOKALODGE	PONOK		TAU 182 notes munimi	
19.	Date Of Immunization(dd	/mm/yyyy):*				
	04/10/2021					
20.	Time of Immunization(If I	(nown)(00:00:00)	NAMES OF THE OWNER O			
	00:00:00		MAN TO			
21.	List all the vaccines given Immunization Information		zation.			
		Vaccine Code	Manufacturer	LotNo.		
		COVPBmR >	BPF-BioNT(✔			

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Please St 🗸	Please Si 🗸
Please S₁ ➤	Please Si 🗸
Please S₁ ∨	Please Si 🗸

Symptoms		Started Date (mm/dd/yyyy)	Resolv	red?	Resolved Date (mm/dd/yyyy)
Other	~	11/01/2021	Yes	~	11/01/2021
None	~		None	~	
None	~		None	~	
None	~		None	~	

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

dizziness, felt like lights closing in

24. Additional Information:

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

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

No 🗸

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

No 🗸

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Dec 23, 2021

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





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1.	Today's Date* 2/11/2021						
2.	Reporter(Your) LastNam Chan	ne*					
3.	Reporter(Your) FirstNam Gregory	ne*					
4.	Reporter (Your) SiteType Physician	e:* •					
5.	If Other SiteType, please	e specify:					and the same
6.	Reporter(Your) Phone#* (only numbers, no -,())	k					
7.	Immunization Facility.		4	•		Tr	other SiteType, please
		Name Shopper's Drug Ma	art	Sit Pharmacy	teType	~	specify
8.	Immunization Facility Ph (only numbers, no -,())	none#					
9.	Immunizing Facility Add	dress					

Building No/Street/PO Box

City/Town

Province

10.	Select Zone: (Click h	<u>ere</u> to determine zone	2.)		
11.	Patient LastName*				
	No. C. Spain				
12.	Patient FirstName*				2
	ATALLES AND SHEET				
13.	If Patient is a minor, the	n Parent/Guardian			
		LastName	FirstName	RelationToPatien	
		* '	-	-	
14.	Patient Sex at Birth:*				
	F-Female V				
15.	Patient/Guardian Phone	#*			
	(only numbers, no -,())				
	403-913-4508				
16.	PHN/ULI Info:				
	636525510	6			
17.	Date Of Birth(dd/mm/y)	/yy)*			
	30/05/1985				
18.	Patient Address:				
		Building No/Street/POBox	City/Town	Province	PostalCode(A1A 1A1)
		5401-58 AVE CL	CONOR	ASP	T4J 1P9
	Date Of Immunization(d	ld/mm/yyyy):*			
	28/06/2021				
20.	Time of Immunization(I	f Known)(00:00:00)			
	00:00:00				
	I A SECOND AT				
21.	List all the vaccines give Immunization Information		ation.		
		Vaccine Code COVPBmR ✓	Manufacturer BPF-BioNT₁ ✓	LotNo.	

-- Please S₁ ✓ -- Please S₁ ✓

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

Sympt	Started Date (mm/dd/yyyy)		Resolv	ved?	Resolved Date (mm/dd/yyyy)
Other	~	09/02/2021	No	~	
None	~		None	~	
None	~		None	~	
None	~		None	~	

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

Change in menstruation

24. Additional Information:

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

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

Yes 🗸

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

Yes 🗸

Note: Hit Done button to Submit the Form.

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Jan 17, 2022

AHS-AEFI request for medical records sent to 1-780-342-0248 verbal consent given Panel Manager:

Jan 17, 2022

GC/PS

GC/PS

GC/PS

GC/PS

GC/PS

GC/PS

GC/PS

GC/PS

as per there is no contradiction and can have further doses in the future

Panel Manager: Jan 17, 2022, 11:40AM





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

1.	Today's Date* 5/11/2021				
2.	Reporter(Your) LastNam Chan	e*			
3.	Reporter(Your) FirstNam Gregory	e*			
4.	Reporter (Your) SiteType Physician	:*			
5.	If Other SiteType, please	specify:			
6.	Reporter(Your) Phone#* (only numbers, no -,())				
7.	Immunization Faciney.	***	•		
		Name	SiteTy	pe	If other SiteType, please specify
	į	Ponoka Professional Pharma	Pharmacy	~	
8.	Immunization Facility Ph (only numbers, no -,())	one#			
0	Immunizing Facility Add	racc			

Building No/Street/PO Box

City/Town

Province

Manufacturer

MODTH-Mc >

-- Please Si V

LotNo.

Vaccine Code

COVMODn V

-- Please St >

Please S₁ ∨	Please Si 🗸
Please S₁ ✔	Please Si 🗸
Please St 🗸	Please Si 🗸

Symptoms		Started Date (mm/dd/yyyy)	Resolved?		Resolved Date (mm/dd/yyyy)	
Fever	~	10/22/2021	Yes	~	10/29/2021	
Severe Diar	rhe 🗸	10/22/2021	Yes	~	10/29/2021	
None	~		None	~		
None	~		None	~		

- 23. If other, describe including Started date & Resolved date:
- 24. Additional Information:

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

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

Yes

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

Yes 🗸

Note: Hit Done button to Submit the Form.

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	adverse event following immunization, please call Health Link			CESSES OF THE PARTY OF THE PART
1.	Today's Date*			
	9/11/2021			
2.	Reporter(Your) LastName*			
	CHAN			
3.	Reporter(Your) FirstName*			
	GREGORY			
				· www.common
4.	Reporter (Your) SiteType:*			1 Allerton Management
	Physician		e e	
5.	If Other SiteType, please specify:			34-10/2000
	or care order, per pressed specify.			
5.	Reporter(Your) Phone#*			THE PROPERTY OF
	(only numbers, no -,())			
	403-783-3399			
7.	Immunization Facility		· James Marie Mari	
	Name	Sit	еТуре	If other SiteType, please
	Rexall			specify
	Rexail	armacy	~	
3.	Immunization Facility Phone# (only numbers, no -,())			
	(only humbers, no -,())			

9. Immunizing Facility Address

403-783-5568

Building No/Street/PO Box

City/Town

Province

14. Patient Sex at Birth:* F-Female

10. Select Zone: Central

11. Patient LastName*

12. Patient FirstName*

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



16. PHN/ULI Info:



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



18. Patient Address:

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

19. Date Of Immunization(dd/mm/yyyy):* 22/10/2021

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

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

> **Vaccine Code** Manufacturer LotNo. COVPBmR > BPF-BioNTi > -- Please St V -- Please Si V

Please Si 🗸	Please Sr 🗸
Please S₁ ∨	Please St 🗸
Please Si 🗸	Please Si 🗸

Symptoms		ns	Started Date (mm/dd/yyyy)	Resolved?		Resolved Date (mm/dd/yyyy)
Other	2	~	30/10/2021	No	~	
None		~		None	~	
None		~		None	~	
None		~		None	~	

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

lesion on tongue

24. Additional Information:

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

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

Yes

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

Yes 🗸

Note: Hit Done button to Submit the Form.

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GC/PS

Dec 2, 2021

call from AHS- 780-702-2653

Investigation into affects after covid vaccine

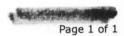
reportable rash recommendation was to receive further doses of the vaccine

she is aware of this recommendation from AHS

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

Panel Manager: Dec 2, 2021, 2:59PM





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 immunizati	on, please call H	lealth Link at 811	or contact your he	ealth provider.	
1.	Today's Date* 15/11/2021					
2.	Reporter(Your) LastName* CHAN					
3.	Reporter(Your) FirstName* GREGORY					
4.	Reporter (Your) SiteType:* Physician					attes at
5.	If Other SiteType, please specify	:			Tolymer Lance (Indonesia A. 10	
6.	Reporter(Your) Phone#* (only numbers, no -,()) 403-783-3399					pubsit 1
7.	Immunization Facility	Name		SiteType	If other SiteType,	please
	Safeway		Pharmac	y	/ reside	
8.	Immunization Facility Phone# (only numbers, no -,()) 403-217-8527					
9.	Immunizing Facility Address	Building				

Buil No/Str

No/Street/PO Box

City/Town

Province

10.	Select Zone: (Click <u>here</u> to determine zo	one.)		E Alberta Health Services
11.	Patient LastName*			E Reporting Form
12.	Patient FirstName*			
	and the entire public with a sit to see			tester Title ivent in her health advence every talk were trav
13.	If Patient is a minor, then Parent/Guardian			
	LastName	FirstName	RelationToPatien	
	-	-		
14.	Patient Sex at Birth:* F-Female ✓			
1 5	Patient/Cuardian Phana #			
15.	Patient/Guardian Phone#* (only numbers, no -,())			
	The second secon			
16.	PHN/ULI Info:			
17.	Date Of Birth(dd/mm/yyyy)*			
	4/07/1997			
18.	Patient Address:			
	Building No/Street/POB	City/Town	Province	PostalCode(A1A 1A1)
	Transmission of the state of th			a state of the sta
	Date Of Immunization(dd/mm/yyyy):*			
	20/09/2021			
20.	Time of Immunization(If Known)(00:00:00 00:00:00)		
21.	List all the vaccines given on date of immunization Information:	nization.		
	Vaccine Code	Manufacturer	LotNo.	
	Almistration COVPBmR ✓	BPF-BioNT₁ ✓		

-- Please Si 🗸

-- Please Si 🗸

Please S₁ ✓	Please Sr 🗸
Please S₁ ✓	Please Si 🗸
Please St V	Please Si 🗸

Sympto	oms	Started Date (mm/dd/yyyy)	Resolv	red?	Resolved Date (mm/dd/yyyy)
Rash	~	09/23/2021	No	~	
Pain and/or	r Sw 🗸	09/20/2021	No	~	
None	~		None	~	
None	~		None	~	

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

Psoriasis

24. Additional Information:

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

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

Yes

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

Yes

Note: Hit Done button to Submit the Form.

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				Page 1 of 1
	Note: This form is for health care pra- adverse event following immunization			
1.	Today's Date* 12/11/2021			
2.	Reporter(Your) LastName*			
3.	Reporter(Your) FirstName* GREGORY			
4.	Reporter (Your) SiteType:* Physician			
5.	If Other SiteType, please specify:			
				To the aid of the state of
6.	Reporter(Your) Phone#* (only numbers, no -,())			4500
7.	Immunization Facility:	Name	SiteType	If other SiteType, please specify
	Ponoka Pr	ofessional Pharma	a Pharmacy ▼	
8.	Immunization Facility Phone# (only numbers, no -,())			
9.	Immunizing Facility Address			

Building No/Street/PO Box

City/Town

Province

Central 🕶	k <u>here</u> to determine zone.			
11. Patient LastName*				
the barriers by the barrier				
12. Patient FirstName*				
13. If Patient is a minor, t	hen Parent/Guardian			
	LastName	FirstName	RelationToPatien	t
	-	-	-	
14. Patient Sex at Birth:*				
M-Male				
15. Patient/Guardian Phor	ne#*			
(only numbers, no -,())				
SOLITON TURB				
16. PHN/ULI Info:				
614189100				
17. Date Of Birth(dd/mm/	yyyy)*			
9/09/1943				
18. Patient Address:				
	Building			PostalCode(A1A
	No/Street/POBox	City/Town	Province	1A1)
	3915 39 ST CLO	PONOKA	AB	T4J 1A9
19. Date Of Immunization 07/10/2021	(dd/mm/yyyy):*			
20. Time of Immunization(If Known)(00:00:00)			
00:00:00				
21. List all the vaccines giv		on.		

COVPBmRN ➤ BPF-BioNTec ➤ Influenza (Aç ➤ Unknown/Oth ➤

Manufacturer

LotNo.

Vaccine Code

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	~	11/11/2021	No	~	
None	~		None	~	
None	~		None	~	
None	~		None	~	

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

24. Additional Information:

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

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

Yes 🕶

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

Yes 🕶

Note: Hit Done button to Submit the Form.

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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. VI STATE OF THE ST 1. Today's Date* 12/11/2021 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 · 专门生使的 **IDA** Ponoka Pharmacy Immunization Facility Phone# (only numbers, no -,()) Immunizing Facility Address

Building No/Street/PO Box

City/Town

AB

1	0. Select Zone: (Click <u>here</u> Central ❖	e_to determine zone.)			
1	1. Patient LastName*				
1.	SOOSAY				
	no trops or bean been although		N PERSON TO STATE		
12	2. Patient FirstName*				
	CHARMAINE DAWN				
13	3. If Patient is a minor, then F	arent/Guardian			
		LastName	FirstName	RelationToPatient	
		-	-	-	
14	. Patient Sex at Birth:*				
	F-Female 🕶				
15	Dations (Co. 1)				
15	<pre>. Patient/Guardian Phone#* (only numbers, no -,())</pre>				
	780-362-0747				
16	. PHN/ULI Info:				
	955259230				
	-				
17.	Date Of Birth(dd/mm/yyyy)	*			
	29/02/19/2				
18.	Patient Address:				
		Building	City/Town	Province	PostalCode(A1A
	service is the property of	No/Street/POBox		- melf	1A1)
	Allegar		ADDITION OF THE PERSON OF THE		TOC TNO
19.	Date Of Immunization(dd/m 10/11/2021	m/yyyy):*			
20					
20.	Time of Immunization(If Kno 00:00:00	wn)(00:00:00)			
21.	List all the vaccines given on	date of immunization			
	Immunization Information:	C or minimization			

Manufacturer

BPF-BioNTec ✔

-- Please Sel ✔

LotNo.

Vaccine Code

COVPBmRN **▽**

-- 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)
Pain and/o	r Swe 🕶	11/11/2021	No	~	
None	~		None	~	
None	~		None	~	
None	~		None	~	

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

Abdominal pain

24. Additional Information:

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

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

Yes 🕶

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

Yes 🕶

Note: Hit Done button to Submit the Form.

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