Dear Doctor / Pharmacist / Health Care Provider:

Complete this report on a person who has received COVID-19 vaccine and experiences an event that required medical attention, was unusual or unexpected, was serious (hospitalization, residual disability, life threatening, fatal outcome) and was suspected to be related to the vaccine. Unusual clusters or high frequency of events should also be reported to your medical health officer / local health unit (by phone/ fax/ email).

For details, see CD Manual. Chapter 2. Immunization. [Part 5. Adverse Events Following Immunization.](http://www.bccdc.ca/resource-gallery/Documents/Guidelines%20and%20Forms/Guidelines%20and%20Manuals/Epid/CD%20Manual/Chapter%202%20-%20Imms/Part_5_AEFI.pdf)

Print and fax the completed form to your local or regional health unit to the number specified here <https://bit.ly/3gbbnT2>.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PATIENT INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name: *(Last)* | | | | | | | | | | | | | | | | | | *(First):* | | | | | | | | | | | *Middle:* | | | | | | | | | | | | | |
| Date of Birth: | | | | | | | *(yyyy/mm/dd)* | | | Health Card Number *(PHN)* | | | | | | | | | | | | | | | | | Gender:  Male  Female  Trans  Unknown | | | | | | | | | | | | | | | |
| Phone Number: | | | | | | | | | | | | | | | Alternate Name(s): | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Address: Unit # | | | | | | Street # | | | | | | | | | Street Name: | | | | | | | | | | | | | | | City: | | | | | | | | | | | | |
| Postal Code: | | | | | | Province: | | | | | | | | | Country of Residence (if outside of Canada): | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **MEDICAL HISTORY** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Current Medications:  Yes  No Unknown If yes, specify | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Known Medical Conditions:  Yes  None  Unknown If yes, specify | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Known Allergies:  Yes  No  Unknown If yes, specify | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **IMMUNIZATION DATA** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Vaccine Name** | | | | | **Date received** *(yyyy-mm-dd)* | | | | | | | | **Lot #** | | | | | | | | | | **Dose #** | | | **Dosage (ml)** | | | | **Route** | | | | | | | **Site** | | | | | |
|  | | | | |  | | | | | | | |  | | | | | | | | | |  | | |  | | | |  | | | | | | |  | | | | | |
|  | | | | |  | | | | | | | |  | | | | | | | | | |  | | |  | | | |  | | | | | | |  | | | | | |
| **Adverse Event** | | | | | | | | | | | | | **Time to Onset (record value for ONE unit)** | | | | | | | | | | **Adverse Event** | | | | | | | | | | | | **Time to Onset (record value for ONE unit)** | | | | | | | |
| **Min** | | | | **HR** | | **Day** | | | | **Min** | | | | **HR** | | | **Day** |
| **Local Reactions at or Near Injection Site** | | | | | | | | | | | | | | | | | | | | | | | **Neurological Events** | | | | | | | | | | | | | | | | | | | |
| 1 | Infected Abscess | | | | | | | | | | | |  | | | |  | |  | | | | 1 | Seizures | | | | | | | | | |  | | | |  | | |  | |
| 2 | Sterile Abscess | | | | | | | | | | | |  | | | |  | |  | | | | 2 | Anesthesia/Paresthesia | | | | | | | | | |  | | | |  | | |  | |
| 3 | Cellulitis | | | | | | | | | | | |  | | | |  | |  | | | | 3 | Meningitis | | | | | | | | | |  | | | |  | | |  | |
| 4 | Nodule | | | | | | | | | | | |  | | | |  | |  | | | | 4 | Encephalopathy/Encephalitis / ADEM Myelitis | | | | | | | | | |  | | | |  | | |  | |
| 5 | Pain or redness or swelling extends past nearest joint | | | | | | | | | | | |  | | | |  | |  | | | | 5 | Guillain-Barré Syndrome | | | | | | | | | |  | | | |  | | |  | |
| 6 | Pain or redness or swelling persisting for 10 days or more | | | | | | | | | | | |  | | | |  | |  | | | | 6 | Bell’s Palsy | | | | | | | | | |  | | | |  | | |  | |
| 7 | Adenopathy/Lymphadenitis | | | | | | | | | | | |  | | | |  | |  | | | | 7 | Transverse Myelitis | | | | | | | | | |  | | | |  | | |  | |
| 8 | Rash at injection site | | | | | | | | | | | |  | | | |  | |  | | | | 8 | Paralysis | | | | | | | | | |  | | | |  | | |  | |
| **Allergic Reactions** | | | | | | | | | | | | | | | | | | | | | | | 9 | Other Neurological – specify: | | | | | | | | | | | | | | | | | | |
| 1 | Anaphylaxis | | | | | | | | | | | | |  | | | |  | |  | | | **Other Events of Interest** | | | | | | | | | | | | | | | | | | | |
| 2 | Allergic reaction (non-anaphylaxis) | | | | | | | | | | | | |  | | | |  | |  | | | 1 | Arthritis | | | | | | | | | |  | | | |  | | |  | |
| **Description of Event:** | | | | | | | | | | | | | | | | | | | | | | | 2 | Thrombocytopenia | | | | | | | | | |  | | | |  | | |  | |
|  | | | | | | | | | | | | | | | | | | | | | | | 3 | Syncope with injury | | | | | | | | | |  | | | |  | | |  | |
| 4 | Thrombosis with Thrombocytopenia Syndrome (TTS) | | | | | | | | | |  | | | |  | | |  | |
| 5 | Myocarditis/Pericarditis | | | | | | | | | |  | | | |  | | |  | |
| 6 | Rash **(non-injection site)** requiring hospitalization | | | | | | | | | |  | | | |  | | |  | |
| 7 | Severe vomiting/diarrhea *(3/24 hours)* | | | | | | | | | |  | | | |  | | |  | |
| 8 | Other severe or unusual – specify: | | | | | | | | | | | | | | | | | | |
| **IMPACT OF AEFI, OUTCOME, AND LEVEL OF CARE OBTAINED** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Highest Impact of AEFI** *(Choose one of the following):* | | | | | | | | | | | | | | | | | | | | | **Outcome at Time of Report** *(Choose one of the following)***:** | | | | | | | | | | | | | | | | | | | | | |
|  | | Did not interfere with daily activities | | | | | | | | | | | | | | | | | | |  | Permanent disability/incapacity | | | | | | | | |  | Fully recovered | | | | | | | | | | |
|  | | Interfered but did not prevent daily activities | | | | | | | | | | | | | | | | | | |  | Not yet recovered | | | | | | | | |  | Unknown | | | | | | | | | | |
|  | | Prevented daily activities | | | | | | | | | | | | | | | | | | |  | Death; specify date *(yyyy-mm-dd)*: | | | | | | | | | | | | | | | | | | | | |
| **Highest Level of Care Obtained** *(Choose one of the following)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Emergency visit | | | | | | | Non-urgent visit | | | | | | | | | | Telephone advice from a health professional | | | | | | | | | | | | | | | | | | | None | | | | Unknown | | |
| Admitted to Hospital (      days) | | | | | | | | | or  Resulted in prolongation of existing hospitalization (by       days) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Hospital Name: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Hospital Admission Date *(yyyy-mm-dd):* | | | | | | | | | | | | | | | | | | | | | Hospital Discharge Date *(yyyy-mm-dd)*: | | | | | | | | | | | | | | | | | | | | | |
| **REPORTER INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name: | | |  | | | | | | | | |  | | | | | | | | | | | | | Phone: | | | | | | | | Fax: | | | | | | | | | |
| *Last* | | | | | | | | | *First* | | | | | | | | | | | | | RN  MD  Pharmacist  NP  Other | | | | | | | | | | | | | | | | | |
|  | | | Email | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Setting: | | | | Physician office | | | | Hospital | | | Pharmacy | | | | | Health Authority Workplace Health | | | | | | | | | | | |  | | | | | | | | | | | | | | |
| Other, specify: | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |