



Vaccine Impact Assistance Program Medical History Form

Privacy notice

The Vaccine Impact Assistance Program (VIAP) is administered by the Public Health Agency of Canada (PHAC) with the support of Service Canada, which is part of Employment and Social Development Canada (ESDC), under agreement with PHAC.

Authorities

The collection of your personal information, including your name, licence information, and business contact information, is authorized by Section 4 of the *Department of Health Act*, Section 3 of the *Public Health Agency of Canada Act*, and subsection 34.1(1) of the *Department of Employment and Social Development Act*. The collection, use, disclosure, retention and disposal of your personal information are governed by the *Privacy Act* and any other applicable laws governing the protection of your personal information by PHAC.

Purpose of collection

PHAC collects your personal information to verify that the claimant is a patient under your care, as well as to be able to contact you with any additional questions about the information you provide about the claimant on this form. Your personal information may be collected, used, and/or disclosed at any stage of the claim process.

Using and sharing your information

Your personal information will be used and disclosed in accordance with the *Privacy Act*. PHAC will share your personal information with Service Canada; Service Canada processes VIAP claims and appeals and provides review-related services under agreement with PHAC.

Refusal to provide requested information

If you choose not to provide some or all of the personal information that is identified as required, information you provide about the claimant may not be accepted or may be accepted only in part by PHAC and Service Canada. If you choose not to provide personal information about the claimant that is identified as required, PHAC and Service Canada may be unable to process the claim, or the processing of the claim may be delayed. As a result, the claimant may be unable to be assessed to receive financial support under the VIAP.

Your rights and how to contact us

You have the right to access and request a correction and/or notation to your personal information. For privacy-related questions, you may contact the VIAP at 1-833-489-0839.

If you have been unable to resolve a privacy issue with us, you may file a formal complaint with the Privacy Commissioner of Canada about how PHAC has handled your personal information.

For more information, visit priv.gc.ca/en/report-a-concern or call 1-800-282-1376.

More information

The collection of your personal information is described on the Access to Information and Privacy Info Source web page at canada.ca/en/public-health/corporate/mandate/about-agency/access-information-privacy/info-source-federal-government-employee-information.html. You may refer to personal information banks (PIB) PHAC PPU 318 – Vaccine Impact Assistance Program, and the ESDC PIB under the same title (currently under development).

Changes to this notice

This privacy notice may be updated periodically at PHAC and ESDC's discretion to reflect legislative, policy, or program changes.

Refer to the Vaccine Impact Assistance Program website for the complete program eligibility policy at canada.ca/vaccine-impact-assistance.

The Public Health Agency of Canada (PHAC) is solely responsible for the assessment of VIAP claims in accordance with program policies.

Vaccine Impact Assistance Program Medical History Form

Instructions:

This form is to be completed by the claimant's primary health care professional. If the claimant does not have a primary health care professional, they may need to visit a walk-in clinic.

Your patient is applying for the Vaccine Impact Assistance Program (VIAP). This form will help determine if they are eligible for the program. If you have any additional information that cannot fit on the form, provide the information on a separate page and submit with the VIAP form. Include the patient's name and the corresponding section number, as well as your name and signature, on each additional page.

Complete this form electronically or print and complete it using black or dark blue ink.

All fields indicated by an asterisk (*) are mandatory.

| Section 1: Patient information | | |
|---|--|------------------------------|
| *Last name | | |
| Given name(s) | | |
| *Date of birth (YYYY-MM-DD) | | |
| Section 2: Health care professional information | | |
| *Last name | | |
| Given name(s) | | |
| *Medical licence number or licence practice number and licensing body | | |
| *Health care specialty | | |
| Section 3: Health care professional contact information | | |
| *Street address | | Office, unit or suite number |
| *City or town | *Province, territory or state | *Country |
| *Postal code or ZIP code | *Email address | |
| *Primary telephone number (incl. area code) | Secondary telephone number (incl. area code) | |

Section 4: Additional health care professionals

Were other health care professionals involved in managing the patient’s medical condition related to this claim?

- Yes (complete below)
- No (skip to Section 5)

4.1 Any additional health care professionals who provided care

*Last name of the additional health care professional who provided care.

*Given name(s) of the additional health care professional who provided care.

*Specialty of the additional health care professional who provided care.

*City or town

*Province, territory or state

*Country

Dates the health care professional was involved in patient care (YYYY-MM-DD)

4.2 Any additional health care professionals who provided care

*Last name of the additional health care professional who provided care.

*Given name(s) of the additional health care professional who provided care.

*Specialty of the additional health care professional who provided care.

*City or town

*Province, territory or state

*Country

Dates the health care professional was involved in patient care (YYYY-MM-DD)

4.3 Any additional health care professionals who provided care

*Last name of the additional health care professional who provided care.

*Given name(s) of the additional health care professional who provided care.

*Specialty of the additional health care professional who provided care.

*City or town

*Province, territory or state

*Country

Dates the health care professional was involved in patient care (YYYY-MM-DD)

To include additional health care professionals, provide the required information on a separate page and submit it with the VIAP claim. Refer to the instructions on page 3.

Section 5: Details of vaccination event

(This section collects information about the administered vaccine related to the patient’s VIAP claim.)

*Date of vaccination (YYYY-MM-DD)

*Province or territory where vaccination occurred

*Vaccine name and/or disease (select all that apply)

| | | | |
|-------------------------|---------------------|-----------------|-------------------------|
| ABRYSVO® | DUKORAL® | Measles, mumps, | Rotavirus |
| ACAM2000® | E.coli | Rubella and | Shingles |
| Act-HIB® | Ebola virus disease | varicella | Shingrix® |
| ADACEL® | Engerix B® | Menactra® | Smallpox |
| ADACEL®-POLIO | Epaxal® Berna | Meningitec® | Spikevax® |
| AFLURIA® | ERVEBO® | Meningococcal | Supemtek® |
| AGRIFLU® | FLUAD® | disease | SYNAGIS® |
| Anthrax | FLUCELVAX® | MENJUGATE® | SYNFLORIX® |
| AREPANRIX® H5N1 | FLULAVAL® | MENOMUNE® | Td® |
| AREXVY® | FluMist® | MenQuadfi® | Td-Polio® |
| AVAXIM® | FLUVIRAL® | MENVEO® | Tdap |
| BEXSERO® | FLUZONE® | M-M-R® | Tdap-Polio |
| BEYFORTUS® | FOCLIVIA® | M-M-RVAXPRO® | Tetanus |
| BioThrax® | FSME-IMMUN® | mNEXSPIKE® | Tetanus and diphtheria |
| BOOSTRIX® | GARDASIL® | MPOX | Tetanus, diphtheria and |
| BOOSTRIX® | Haemophilus | mRESVIA® | pertussis |
| -POLIO | influenzae | NeisVac-C® | Tick-borne encephalitis |
| CAPVAXIVE® | Hepatitis A | Nimenrix® | Travellers’ diarrhea |
| CERVARIX® | Hepatitis B | NUVAXOVID® | TRIPACEL® |
| Chikungunya | Hepatitis A and | PEDIACEL® | Trumenba® |
| Cholera | typhoid | PedvaxHIB® | Twinrix® |
| COMIRNATY® | Herpes Zoster | PENTACEL® | TYPHERIX® |
| COVID-19 | Hiberix® | Pneumo 23 | TYPHIM® |
| COVIFENZ® | Human | Pneumococcal | Typhoid |
| COVISHIELD® | papillomavirus | disease | VAQTA® |
| Cytomegalovirus | IMOVAX POLIO® | Pneumovax® | Varicella |
| Diphtheria | Imovax Rabies® | Poliomyelitis | VARILRIX® |
| Diphtheria, tetanus, | IMVAMUNE® | PREHEVBRIO® | VARIVAX® |
| pertussis and | INFANRIX® | Prevnar® | VAXCHORA® |
| poliomyelitis | Influenza | Priorix® | Vaxigrip® |
| Diphtheria, tetanus, | INFLUVAC® | ProQuad® | VAXNEUVANCE® |
| pertussis, | Intanza® | QUADRACEL® | VAXZEVRIA® |
| poliomyelitis and | IXCHIQ® | RabAvert® | VIVAXIM® |
| haemophilus | IXIARO® | Rabies | Vivotif® |
| influenzae infection | Japanese | RECOMBIVAX | Yellow fever |
| Diphtheria, tetanus, | encephalitis | HB® | YF-VAX® |
| pertussis, hepatitis B, | JCOVDEN® | Respiratory | ZOSTAVAX® |
| poliomyelitis and | Measles, mumps | syncytial virus | Other (specify): |
| haemophilus | and rubella | (RSV) | _____ |
| influenzae | | ROTARIX® | |
| | | RotaTeq® | |

Section 6: Details of medical condition related to claim
 (Responses should be limited to medically relevant information necessary for reviewing the VIAP claim.)

*When did the patient’s symptoms first appear after receiving the vaccine? (YYYY-MM-DD)

*When did the patient first present to you with symptoms related to this claim? (YYYY-MM-DD)

*What is the medical condition or diagnosis related to this claim?

When did you as the health care professional first suspect a relationship between the symptoms and the vaccine? (YYYY-MM-DD)

*What is the current health status of the patient? (select one)

- Recovered
- Recovering
- Stable
- Unknown
- Worsening
- Deceased
- Other (specify) _____

*Describe the serious and permanent injury, medical condition or event related to this claim.

Permanent: A medical condition is considered permanent when examinations and accepted medical knowledge do not point to any significant foreseeable improvement in the individual’s condition.

Serious: A life-threatening or life-altering medical condition that may require in-person hospitalization or prolongs an existing hospitalization and results in a persistent or significant disability or incapacity. It may also be a condition where the outcome is a congenital malformation or death.

Section 7: Patient’s medical history

*Have you examined or treated this patient before the medical diagnosis related to this claim?
(choose one)

- Yes
- No

*Are you aware of pre-existing injuries or conditions that may impact the course of the claimant's diagnosis? (choose one)

- Yes
- No

If “Yes”, describe pre-existing injuries or conditions and how they may impact the course of the claimant’s diagnosis.

*List the patient’s medications at the time of vaccination.
Write not applicable (N/A) if there are no medications.

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

*List any discontinued medications.
Write not applicable (N/A) if there are no medications.

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

*List any new medications.
Write not applicable (N/A) if there are no medications.

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

Section 8: Additional comments

Provide any additional information not captured through this medical history form that would be helpful for reviewing the VIAP claim.

Signature of health care professional (required)

*Signature of health care professional _____

*Name of health care professional _____

*Date of signature (YYYY-MM-DD) _____

