

# PUBLICLY FUNDED VACCINE PROBLEM REPORT

Fax or mail this completed report to the Saskatchewan Ministry of Health  
MAIL: PHN Consultant - Immunization  
Saskatchewan Ministry of Health  
1st Floor, 3475 Albert Street, Regina SK S4S 6X6  
FAX: 306-787-3237

## Instructions

- Complete all applicable sections on page 1 and 2
- Please attach or fax a Vaccine Wastage Report for this product  
**EXCEPTION:** A Wastage Report is **not** required when reporting less than full number of doses in a COVID-19 vaccine vial.
- A Vaccine Problem Report is to be completed when there is defective or damaged product. **Please include a picture whenever possible.**
- Not all Vaccine Wastage Reports will require a Vaccine Problem Report.

Check Yes or No as applicable:

Wastage Report Attached Yes  No  OR

(Non-COVID-19 Vaccines ONLY): Wastage Report Faxed to RRPL Y  N

1. Reporter name (print): \_\_\_\_\_
2. Jurisdiction/Region: \_\_\_\_\_
3. Is product (without needle attached) being returned with this report? Yes  No
4. Date the incident occurred: YYYY/MM/DD \_\_\_\_\_
5. Vaccine brand name: \_\_\_\_\_
6. Manufacturer name: \_\_\_\_\_
7. Lot number(s): \_\_\_\_\_
8. Number of doses affected: \_\_\_\_\_
9. Problem/Issue Type:

<input type="checkbox"/>	Dull or missing needle
<input type="checkbox"/>	Needle separated from syringe during administration
<input type="checkbox"/>	Contents cloudy
<input type="checkbox"/>	Contents contains particles
<input type="checkbox"/>	Illegible label or lot number
<input type="checkbox"/>	Label missing
<input type="checkbox"/>	Other –

Details of the problem-issue, including any visible colour or consistency observations in the volume. **For needle/syringe issues (ex. leakage), indicate the brand and size of each.**

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Revised Dec 20, 2021

Date received at MOH \_\_\_\_\_

MoH Reference # \_\_\_\_\_

Saskatchewan 

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### 10. COVID-19 Vaccines- Drawing less than the full number of doses

**NOTE: One less dose does not need to be reported for Pfizer 12+ vaccine or Moderna vaccine.**

- a. How many vials were affected? \_\_\_\_\_
- b. How many doses were obtained from the vial(s)? \_\_\_\_\_
- c. Syringe Type:
  - Administration:  Low dead space (LDS) 1mL  Non-LDS 1mL  3mL  
Brand: \_\_\_\_\_
  - Reconstitution (if applicable):  LDS 1mL  Non-LDS 1mL  3mL  
Brand: \_\_\_\_\_
- d. Needle Type:
  - Administration:  25G 1"  25G 1.5"  Other: \_\_\_\_\_  
Brand: \_\_\_\_\_
  - Reconstitution (if applicable):  21G 1"  21G 1.5"  Other: \_\_\_\_\_  
Brand: \_\_\_\_\_
- e. Was the vial inspected prior to reconstitution/administration? Yes  No

### 11. Name and contact information for further follow up:

\_\_\_\_\_

Please indicate if contact information can be provided to the Manufacturer for their direct follow-up: Yes  No