

Anthrax Vaccine in Pregnancy Registry Referral Form

PATIENT IDENTITY KEPT CONFIDENTIAL

For office use only:

Study Referral Number: _____

Supplemental Information for BioThrax® Anthrax Vaccine in Pregnancy RegistryReturn to NHRC-VaccineRegistry@mail.mil via encrypted email or secure FAX 619-767-4806

Telephone: 619-553-9255 or DSN 553-9255. POC: LtCol. Susan Farrish

Other ways to report Vaccine Adverse Events: <http://vaers.hhs.gov>, 800-822-7967, PO Box 1100, Rockville, MD 20849-1100
 Clinical consultation on vaccination issues may be referred to the Defense Health Agency (DHA)-Immunization Healthcare Branch (IHB),
www.vaccines.mil, Immunization Healthcare Support Center, 1-877-438-8222 or DSN 761-4245

Patient Name:

Last 4 digits of Patient's SSN:

Patient date of birth: MM-DD-YYYY Age:

Patient mailing address:

Form completed by:

Email and/or phone:

Relation to patient:

Date form completed: MM-DD-YYYY

Patient email and phone:

Patient military rank, MOS, and branch of service:

Patient military unit and location:

Date anthrax vaccination given: MM-DD-YYYY

Dose# if known:

Lot #:

Any illness at the time of vaccine? Yes No

If yes, please describe:

Was a VAERS report submitted to VAERS at <http://vaers.hhs.gov> ? Yes No

If so please provide VAERS report Number:

Healthcare provider has discussed potential risks associated with receipt of the anthrax vaccine in pregnancy with the patient. Yes NoRegistry Information/Invitation Sheet was provided to the patient? Yes No

Vaccination facility name/location:

Was smallpox vaccination administered the same day as anthrax? Yes NoIf so was a smallpox vaccination pre-screening form completed? Yes NoWere any other vaccines administered the same day as the anthrax vaccine or within 4 weeks of anthrax vaccination date? Yes No If Yes, please list other vaccines and dates administered:

Vaccine:

Date administered:

Was pregnancy test done on day of vaccination? Yes No

Date pregnancy diagnosed: MM-DD-YYYY

Date of last normal menstrual period: MM-DD-YYYY

Estimated Date of Delivery (EDD): MM-DD-YYYY

If ultrasound used for gestational age, provide result:

Method of birth control at time of conception:

Number of previous pregnancies: List outcomes (with dates) of any pregnancies.

Medical facility where patient will be followed (Provider contact/address/phone):