Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

Annex F: COVID-19 Vaccine Injury Survey

IMPORTANT REMINDERS IN FILLING OUT THE FORM:
1. Please append with this Survey any supporting documents to provide medical evidence of the responses captured in this survey.
2. Do not accomplish this survey by yourself, the form is designed to be accomplished by duly licensed physicians.
3. The survey needs to be signed and confirmed by at least one duly licensed physician.
4. Please provide as much detail as possible in filling out the survey.
5. All information required in this survey are necessary.
6. False/incorrect information or misrepresentation shall be subject to criminal, civil or administrative liabilities.

Special Note: The COVID-19 Vaccine Injury Survey was patterned from the WHO COVAX Supporting Evidence Form

PART I - PRINCIPAL INFORMATION

1. PhilHealth Identification Number (PIN) of Principal: - -
2. Date of Birth: month - date - year

3. Name of Principal:
Last Name (ex. DELA CRUZ) | First Name (ex. Juan) | Middle Name (ex. SIPAG) | Suffix

4. Mailing Address
Unit/Room No./Floor | Building Name | Lot/Blk/House/Bldg. No. | Street
Subdivision/Village | Barangay | City/Municipality
Province | Country | Zip Code

5. Contact Information:
Landline No. Area Code - Number
Mobile No. + Country Code - Number (ex.91XXXXXXXX)
Email Address @

5. Sex: Male Female

7. Principal is the Claimant? Yes (Skip Part II, proceed to Part III) No (Fillout Part II)

PART II - HEALTH PROFESSIONAL INFORMATION

1. Name of Licensed Physician 1:
Last Name (ex. DELA CRUZ) | First Name (ex. Juan) | Middle Name (ex. SIPAG) | Suffix

Professional Regulatory Commission (PRC) License
Registration No.
Registration Date: month - date - year
Valid Until: month - date - year

Contact Information of Physician 1:
Landline No. Area Code - Number
Mobile No. + Country Code - Number (ex.91XXXXXXXX)
Email Address @

5. Sex: Male Female

Health Care Facility Address
Name of Health Care Facility
Unit/Room No./Floor | Building Name | Lot/Blk/House/Bldg. No. | Street
Subdivision/Village | Barangay | City/Municipality
Province | Country | Zip Code

2. Name of Licensed Physician 2 (Skip section if only one physician filled out the survey):
Last Name (ex. DELA CRUZ) | First Name (ex. Juan) | Middle Name (ex. SIPAG) | Suffix

Professional Regulatory Commission (PRC) License
Registration No.
Registration Date: month - date - year
Valid Until: month - date - year

Contact Information of Physician 2:
Landline No. Area Code - Number
Mobile No. + Country Code - Number (ex.91XXXXXXXX)
Email Address @

5. Sex: Male Female

Health Care Facility Address (Skip if same as Physician 1)

Name of Health Care Facility

Unit/Room No./Floor | Building Name | Lot/Blk/House/Bldg. No. | Street

Subdivision/Village | Barangay | City/Municipality

Province | Country | Zip Code

3. Name of Licensed Physician 3 (Skip section if only one physician filled out the survey):

Last Name (ex. DELA CRUZ) | First Name (ex. Juan) | Middle Name (ex. SIPAG) | Suffix

Professional Regulatory Commission (PRC) License

Registration No. Registration Date: month - date - year Valid Until: month - date - year

Contact Information of Physician 3:

5. Sex: Male Female

Landline No. Area Code - Number Mobile No. + Country Code - Number (ex.91XXXXXXXX)

Email Address @

Health Care Facility Address (Skip if same as Physician 2)

Name of Health Care Facility

Unit/Room No./Floor | Building Name | Lot/Blk/House/Bldg. No. | Street

Subdivision/Village | Barangay | City/Municipality

Province | Country | Zip Code

PART III - COVID-19 VACCINE INFORMATION

Special Note: If more than one type of vaccine or if multiple doses of the same vaccine was administered, repeat this section

1. Details of the Vaccine administered to the patient (or in the case of birth defects, to the Patient's mother).

Name of Vaccine

Dose administered (check if provided: 1 Expiry Date (dose 1): month - date - year

Batch / Lot No:

2 Expiry Date (dose 2): month - date - year

2. If known, details of diluent (if any) used with the Vaccine administered to the Patient (or in the case of birth defects, to the Patient's mother).

Name of Vaccine

Dose administered (check if provided: 1 Expiry Date (dose 1): month - date - year

Batch / Lot No:

2 Expiry Date (dose 2): month - date - year

3. Other Relevant Information

4. Date(s) and places(s) the Vaccine was administered to Patient (or in the case of birth defects, to the Patient's mother).

Dose 1 month - date - year Vaccine Administration Site

Dose 2 month - date - year Vaccine Administration Site

PART IV - INFORMATION ABOUT THE INJURY OR ILLNESS SUSTAINED

1.. Describe the injury or illness suffered by the Patient after the Vaccine was administered to Patient (or in the case of birth defects, to the Patient's mother).

Description of the Injury:	Examination and tests conducted	Any known relevant congenital birth injuries or defects that is related to the injury

2. Regarding symptoms, please describe the following:

In providing the details of any sequelae, please mention:

a. any severe local reaction suffered by the Patient after the Vaccine administered to him/her (and whether that reaction extended beyond nearest joint); and

b. any seizures (febrile or afebrile), abscess, sepsis, encephalopathy, toxic shock syndrome, thrombocytopenia, anaphylaxis, fever (above 38 degrees centigrade).

Symptom Experienced	Date (month - date - year)	Extent of seriousness of the symptom	Details of the Sequielae
	- -		
	- -		
	- -		
	- -		
	- -		
	- -		
	- -		
	- -		
	- -		
	- -		

3. Did the Patient require any treatment for the injury or illness suffered by the Patient after the vaccine was administered to him/her (or in the case of birth defects, to the Patient's mother)? If yes, please describe what treatment was provided to the Patient for the injury/illness suffered by the Patient after the Vaccine was administered to him/her (or in the case of birth defects, to the Patient's mother).

4. Please describe to what extent the Patient has or has not (as applicable) recovered from the injury or illness suffered by the Patient after the Vaccine was administered to him/her (or in the case of birth defects, to the Patient's mother).

5. In your opinion, what was the cause of the injury or illness suffered by the Patient? Please elaborate your response.

6. If known, please provide the date and place when the injury or illness suffered by the Patient was first reported to a Registered Healthcare Professional or to the health system

Reported Injury	Date (month - date - year)	Reported place of Injury
	- -	
	- -	
	- -	
	- -	
	- -	
	- -	
	- -	
	- -	
	- -	
	- -	

7.Describe the extent of any permanent impairment of the Patient and the prognosis for the Patient as a result of such impairment

8. What is the functional impact on the Patient of the injury or illness suffered by the Patient (or in the case of birth defects, to the Patient's mother)?

9. Details of any hospitalization, or prolongation of existing hospitalization, of the Patient for more than 24 consecutive hours in connection with the injury or illness suffered by the Patient after the Vaccine was administered to the Patient (or in the case of birth defects, to the Patient's mother)

Date of Admission			Date of Discharge			Type of care or treatment provided to the patient during hospitalization her (or in the case of birth defects, to the Patient's mother)
month	date	year	month	date	year	

10. Details of any medicines taken by, and/or any other vaccines administered to, the Patient after the Vaccine was administered to the Patient and/or during the period of 6 weeks before such administration

Name of Medicine / Vaccine	Dose	Date of Administration / Prescription		
		month	date	year

11. In the case of birth defects, details of any medicines taken by, and/or any othervaccines administered to, the Patient's mother during the pregnancy and/or 6 weeks before the start of the pregnancy

Name of Medicine / Vaccine	Dose	Date of Administration / Prescription		
		month	date	year

12. Details of previous long-term medication, to the extent known. Details of any medicines not described above that were taken by the Patient for a consecutive period of more than 3 weeks, during the 24 months before the Vaccine was administered to the Patient, including:

Name of Medicine / Vaccine	Dose	Date of Administration / Prescription		
		month	date	year

13. Details of any known pre-existing medical conditions of the Patient or in the case of birth defects, of the Patient's mother (i.e., medical conditions existing before the period the Vaccine was administered to the Patient or in the case of birth defects, to the Patient's mother)

14. Has the Patient suffered any similar injury or illness before? If yes, please describe the previous similar injury or illness.

15. In the case of birth defects, did the Patient's mother have another unborn or new-born child with a congenital birth injury or illness? If yes, please provide details.

16. In your opinion, is it possible that the injury or illness suffered by the Patient after the Vaccine was administered to the Patient (or in the case of birth defects, to the Patient's mother) was caused by, or resulted from, any previous injury or illness of the Patient (or in the case of birth defects, of the Patient's mother)? If yes, please provide details.

17. To the extent known, has a close family member of the Patient, such as brother, sister, parent, child, aunt, uncle, or 1st cousin, suffered any similar injury or illness before? If yes, please indicate which close family member and describe the similar injury or illness.

18. Have you seen any injury or illness similar to that suffered by the Patient amongst other patients who received (or in the case of birth defects, whose mother received) the same Vaccine?

19. Has the patient died due to the vaccine injury? ☐ Yes, proceed to next section ☐ No, skip PART V

PART V - INFORMATION ABOUT THE PATIENT'S DEATH

1. Date of Patients Death

__ __ - __ __ - __ __ __ __
month date year

2. Cause/s of death stated on the death certificate

3. Autopsy details (if available)

4. In your opinion, what is/are the cause of death of the patient? Please elaborate on your answer.

5. Have you seen death similar to that suffered by the Patient among other patients who received the same Vaccine as the Patient? If yes, please provide details.

6. Other Information

PART VI - DECLARATION AND SIGNATURE OF LICENSED PHYSICIAN

By signing below, I/we hereby certify that:
1. before this Supporting Evidence form was completed, a waiting period of 30 days has been observed since the Vaccine was administered to the Patient (or in the case of birth defects, to the Patient's mother); and
2. the statements and answers contained in this survey form are true and correct to the best of my/our knowledge and belief.

I/We understand that should these statement or answers not be true, PhilHealth shall have the right, where applicable, to conduct further investigation and pursue legal action.

Date Signed ☐☐ - ☐☐ - ☐☐☐☐
month date year

Physician 1 ______________________
Signature over Printed Name

Date Signed ☐☐ - ☐☐ - ☐☐☐☐
month date year

Physician 2 ______________________
Signature over Printed Name

Date Signed ☐☐ - ☐☐ - ☐☐☐☐
month date year

Physician 3 ______________________
Signature over Printed Name

NOTES ON REQUIRED ATTACHMENTS TO THE CLAIM

1. Please provide documentation confirming that the Vaccine was administered to the Patient (or in the case of birth defects, to the Patient's mother). This includes a copy the immunization card or certificate, a copy of the service point immunization log documenting the administration of the Vaccine, or any other government document that shows proof of vaccine administration

2. Please attach a copy of all available medical documentation and records related to the injury or illness sustained by the Patient after administration of the Vaccine. This inclides the case sheet, case notes, discharge summary, laboratory reports, autopsy report, as well as prescriptions for concomitant and/or long-term medication, as referred to above, etc. if available.

3. If available, please also attach a copy of the AEFI investigation form, AEFI committee causality assessment, and other related documentation.

4. If space alloted in the specific section of this survey is insufficient, please fill out the details in a separate sheet of the applicable section and append it to the survey.