Saskatchewan

Cold Chain Break Report Form

SHA, ISC, NITHA facilities and external providers: fax or email to your regional Immunization Coordinator

Community Pharmacies: fax to the Ministry of Health at 306-787-3237

Complete for all publicly funded products. Do not assume that products must be wasted.

Clearly complete pages 1 & 2 of this report. Reports with missing information will be returned for completion.

SECTION 1

1. Date of Break: *(YYYY-MM-DD)*

2. Report Date: *(YYYY-MM-DD)*

3. Reporter Name: *(PRINTED)*

4. Phone #:

5. Fax #:

6. Email Address:

7. Organization (SHA Network, NITHA, ISC, AHA):

8. Community:

9. Facility/Pharmacy Name:

10. Facility type: ☐Public Health ☐Pharmacy ☐Physician office ☐Primary Health Care ☐Long-Term Care ☐Acute Care ☒Employee Health ☐Other (specify):

11. Are products quarantined, labeled DO NOT USE and stored on cold chain? ☒Yes ☐No *(attach explanation if no)*

SECTION 2

Select only one of the following categories (A, B or C) and complete all related fields

A ☐ Vaccine left out of fridge/freezer

1. ☐ In cooler with cold packs ☐ In cooler without cold packs ☐ In package on counter ☐ Out of package on counter
2. Products returned to recommended storage temperature on: *(YYYY-MM-DD)* at: *(HH:MM)*
3. **Maximum** length of time outside recommended temperature range: *(HH:MM)*
4. Room temperature at time excursion was identified: _____ºC on: *(YYYY-MM-DD)* at: *(HH:MM)*

B ☐ Fridge/freezer temperature excursion

1. Fridge/freezer temperature when break identified: _____ ºC on: *(YYYY-MM-DD)* at: *(HH:MM)*
2. Max. temp recorded during break _____ ºC Min. temp recorded during break _____ ºC
3. Products returned to recommended storage temperature range on: *(YYYY-MM-DD)* at: *(HH:MM)*
4. **Maximum** length of time outside recommended temperature range: *(HH:MM)*
5. Last fridge/freezer temperature recorded before the break _____ ºC on: *(YYYY-MM-DD)* at: *(HH:MM)*
6. Is temperature log being submitted? ☐Yes ☐No *If No, indicate why*:
7. Refrigerator/freezer type: ☐ Lab Fridge ☐ Biological Fridge ☐ Domestic Fridge ☐ ULT Freezer ☐ Regular Freezer ☐ Thermal Shipper ☐ Other (specify):
8. Date fridge/freezer last serviced: *(YYYY-MM-DD)*
9. Thermometer/Monitor Type (Not Brand Name): ☐ Digital Min/Max ☐ Smart Button/Data Logger ☐ Warm/Cold Mark ☐ Unit temperature not monitored ☐ Other (specify):

C ☐ Break during transportation

1. Transportation category: ☐ From RRPL to a facility ☐ From a wholesaler to a pharmacy ☐ From a facility to a facility
2. Vehicle type (e.g. car/courier):
3. Time delivery received: *(HH:MM)*
4. Time when unpacked: *(HH:MM)*
5. Was a data logger included in the cooler/container? ☐ Yes (attach copy of report) ☐ No

SECTION 3

Description of cold chain break:

1. Cause of cold chain break: ☐ Human error ☐ Power outage ☐ Backup generator failed ☐ Thermometer malfunction ☐ Refrigerator malfunction ☐Other (specify):

2. Corrective action taken:

3. Were any affected products administered to clients? ☐ No ☐ Yes (*identify administered products with an asterisk* on page 2 or use a separate page if necessary*).

Clearly complete pages 1 & 2 of this report. Reports with missing information will be returned for completion.

Once completed, fax according to the instructions on page 1.
Clearly complete pages 1 & 2 of this report. Reports with missing information will be returned for completion.

Go to http://www.ehealthsask.ca/services/manuals/Documents/sim-chapter9.pdf for further instructions.

Vaccine Brand or Abbreviation	Manufacturer	# Doses	Lot Number	Expiry date	Presentation *	Is MDV punctured (open)?	Previous cold chain break?	SK Health USE ONLY	
								VIABLE	NOT VIABLE - DISCARD
					☐PFS ☐MDV	☐ Yes ☐ No	☐ Yes ☐ No	☐	☐
					☐PFS ☐MDV	☐ Yes ☐ No	☐ Yes ☐ No	☐	☐
					☐PFS ☐MDV	☐ Yes ☐ No	☐ Yes ☐ No	☐	☐
					☐PFS ☐MDV	☐ Yes ☐ No	☐ Yes ☐ No	☐	☐
					☐PFS ☐MDV	☐ Yes ☐ No	☐ Yes ☐ No	☐	☐
					☐PFS ☐MDV	☐ Yes ☐ No	☐ Yes ☐ No	☐	☐
					☐PFS ☐MDV	☐ Yes ☐ No	☐ Yes ☐ No	☐	☐
					☐PFS ☐MDV	☐ Yes ☐ No	☐ Yes ☐ No	☐	☐
					☐PFS ☐MDV	☐ Yes ☐ No	☐ Yes ☐ No	☐	☐
					☐PFS ☐MDV	☐ Yes ☐ No	☐ Yes ☐ No	☐	☐
					☐PFS ☐MDV	☐ Yes ☐ No	☐ Yes ☐ No	☐	☐
					☐PFS ☐MDV	☐ Yes ☐ No	☐ Yes ☐ No	☐	☐
					☐PFS ☐MDV	☐ Yes ☐ No	☐ Yes ☐ No	☐	☐
					☐PFS ☐MDV	☐ Yes ☐ No	☐ Yes ☐ No	☐	☐
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					☐PFS ☐MDV	☐ Yes ☐ No	☐ Yes ☐ No	☐	☐
					☐PFS ☐MDV	☐ Yes ☐ No	☐ Yes ☐ No	☐	☐
					☐PFS ☐MDV	☐ Yes ☐ No	☐ Yes ☐ No	☐	☐
					☐PFS ☐MDV	☐ Yes ☐ No	☐ Yes ☐ No	☐	☐

Ministry of Health Reviewer:

Date:

Reviewer comments:

*PFS = pre-filled syringe **OR** single-dose vial
*MDV = multidose vial