

**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 Registry**

Return to [NHRC-VaccineRegistry@med.navy.mil](mailto:NHRC-VaccineRegistry@med.navy.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 Vaccine Healthcare Centers, [www.vhcinfor.org](http://www.vhcinfor.org), 301-319-2904

Patient Name:

Form completed by:

Last 4 digits of Patient's SSN:

Email and/or phone:

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

Relation to patient:

Patient mailing address:

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  No

Registry Information/Invitation Sheet was provided to the patient?  Yes  No

Vaccination facility name/location:

Was smallpox vaccination administered the same day as anthrax?  Yes  No

If so was a smallpox vaccination pre-screening form completed?  Yes  No

Were 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):

