BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

VACCINE RETURN FORM

THIS FORM MUST ACCOMPANY ALL VACCINE RETURNS

Health Care Provide/Pharmacy Name:	**Phone #:**
Date of Return:	**Date of Cold Chain Incident (if applicable):**

Name of Vaccine	**# of doses** (not # of boxes)	**Lot #**	**Expiry Date**	**Reason for Return** (see codes below)

Please write code in the "Reason for Return" column:

CCH- Cold Chain Incident (Human Error)
CCM – Cold Chain Incident (Fridge/Equip. Malfunction)
CCP – Cold Chain Incident (Power Outage)
DP – Damaged Product
EQ – Excessive Quantity (flu vaccine only)
EX – Expired Product
FC – Facility Closure