ADVERSE MEDICAL INCIDENT REPORT

CASE NUMBER:

ADMITTING COMPLAINT:

DATE OF INCIDENT (including time):

DATE OF REPORT:

NAME OF REPORTER (please print):

PATIENT INFORMATION (blue card stamp, if available):

PATIENT STATUS AT TIME OF INCIDENT (e.g. post-surgical): __________________________________________________________

LOCATION OF INCIDENT: ______________________________________________________

STAFF PRESENT OR INVOLVED (e.g. names of clinicians, nurses, students, administrators):

________________________________________________________________________________

________________________________________________________________________________

WITNESSES (OTHER THAN THOSE INVOLVED) (e.g. client):

________________________________________________________________________________

________________________________________________________________________________

EQUIPMENT IN USE (if any):

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________________________________________________________________________________

DESCRIPTION OF INCIDENT/OCCURRENCE (use back of form if necessary):

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INDIRECT COSTS OF ERROR: (list additional supplies or procedures incurred because of event, if any)

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________________________________________________________________________________

DATE REPORT RECEIVED BY HOSPITAL DIRECTOR: ________________________________

Please return completed forms to: Dr. F. Gaschen or Mr. A. Desselle

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AND WILL BE MAINTAINED AS A CONFIDENTIAL DOCUMENT.