Event/Complaint Report

CONFIDENTIAL REPORT OF EVENT. THIS REPORT SHOULD NOT BE INCLUDED IN THE PATIENT RECORD.

SECTION 1. General Information

Name: _____ Date of Event: _____

Address: _____ Time of Event: _____ AM / PM

_____ Phone #: _____

☐ Patient ☐ Male Record #: _____

☐ Visitor ☐ Female

Age: _____

Reason for Visit: _____

Location of Event (be specific): _____

_____

SECTION 2. Type of Event/Complaint (check all that apply)

☐ Bodily Injury (not resulting from a fall, procedure or equipment)

☐ Chemical	☐ Electrical	☐ Heating appliance
☐ Hot liquid	☐ Exposure to hazardous material	
☐ Other (specify)		

☐ Equipment/Medical Device Related

☐ Disconnected/dislodged	☐ Electric power outage	☐ User related
☐ Mechanical issue	☐ Availability	
☐ Other (specify)		

☐ Fall

☐ Dropped	☐ Found on floor	☐ Off scale/equipment
☐ Fainted	☐ Off chair/bed/exam table	☐ While ambulating
☐ Other (specify)		

☐ Medication Related

☐ Adverse reaction	☐ Route	☐ Dosage
☐ Drug selection	☐ Medication missing	☐ Prescription pad missing
☐ Patient identification	☐ Other (specify)	

☐ Patient Action Influencing Care

☐ Non-compliance	☐ Left AMA	☐ Left without being seen
☐ Refused treatment	☐ Other (specify)	

☐ Patient Care Related

☐ Adverse reaction	☐ Consent related	☐ Patient monitoring
☐ Procedure related	☐ Specimen issue	☐ Tracking consultations/referrals
☐ Infection control (infections, exposure, sharps)	☐ Reporting/tracking of test results	☐ Medical emergency (i.e. 911 called)
	☐ Other (specify)	

☐ Other

☐ Missing/damaged property	☐ Communication related	☐ Corporate compliance
☐ Patient complaint	☐ Non-medical emergency (i.e. fire, flood)	☐ Unauthorized disclosure of protected health information
☐ Security related	☐ Payment/billing related	
☐ Violence to self or others/use of weapon	☐ Other (specify)	

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SECTION 3. Additional Information

Brief factual description of the event, including key observations and patient's statement if not witnessed by staff (if medication related, indicate name of medication): _____

_____

_____

Injuries and parts of the body involved (i.e. bruised right knee): _____

_____

Pre-existing issues (i.e. impaired mobility, cognitive factors, functional factors, environment, equipment, assistive devices):

_____

_____

Preventative measures in place prior to event (i.e. assistive devices, precautions, instructions): _____

_____

_____

Severity of the Injury ☐ Minor ☐ Significant ☐ Death ☐ Unknown ☐ N/A
Person Examined ☐ Yes ☐ No ☐ Declined
Treatment Provided ☐ Yes ☐ No ☐ Declined ☐ Not indicated
Treatment Provided by _____
Type of Treatment Provided ☐ First Aid ☐ 911 Called ☐ Medical ☐ CPR/Defib
Be Specific: _____

Equipment/Medical Device Involved ☐ Yes ☐ No
Manufacturer: _____
Model #: _____ Lot/Batch #: _____
Secured/Removed from Service & Labeled "Not for Use" ☐ Yes ☐ No
Location: _____

Witness(es):
Name: _____
Address: _____
Phone #: _____

Name: _____
Address: _____
Phone #: _____

Authorities/Police Notified ☐ Yes ☐ No ☐ N/A
Authoritative Agency(ies): _____ Date/Time Notified: _____ AM / PM

Family Notified ☐ Yes ☐ No ☐ N/A
Name of Family Member Notified: _____ Date/Time Notified: _____ AM / PM

Name of Practice Manager/Physician/Dentist Director Notified: _____
Date/Time Notified: _____ AM / PM

Staff Person Completing Report:

_____ _____
Print Name & Title Signature & Date

Practice Manager/Physician/Dentist Director Reviewing Report:

_____ _____
Print Name & Title Signature & Date