ADVERSE EVENT REPORT

Clinic Information

Clinic Name____

Address ____

City____________________________________ State __________________ Zip__________

Phone ( ) ________________________ Fax ( ) __________________________

NAME & TITLE OF PERSON COMPLETING THE REPORT:

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____

PARTIES INVOLVED

Name of Patient____

Date of Incident_________________________

Was there more than one patient involved? Yes__________ No___________

Perpetrator (if any) ____

Name and title of all staff aware of the incident _____________________________________

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Brief description of the event: ____

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Outside Medical Attention

Was outside medical attention required? Yes__________ No___________

Where and by whom: ____