DREXEL UNIVERSITY College of Medicine

CONFIDENTIAL ADVERSE EVENT FORM

Confidential and Protected Under the Pennsylvania Peer Review Act

NOT PART OF THE MEDICAL RECORD / DO NOT SCAN OR PHOTOCOPY

DO NOT USE FOR EMPLOYEE WORK RELATED INJURIES

Fax to: Office of Risk Management 267-359-6271 *and* Quality Management 215-255-7305

STATUS: ☐ INPATIENT ☐ OUTPATIENT ☐ VISITOR ☐ OTHER (Specify): _____	**PATIENT/VISITOR NAME:**
INCIDENT DATE: / **REPORT DATE:** / **TIME OF INCIDENT:** ☐ AM ☐ PM	**SEX:** M ☐ F ☐ **HOME ADDRESS:**
FACILITY LOCATION: (BUILDING, FLOOR, ROOM NUMBER)	**PHONE NUMBER:** **DATE OF BIRTH:**
INCIDENT TYPE: ☐ **NEAR MISS** ☐ **ACTUAL EVENT**	**TREATING PHYSICIAN (IF APPLICABLE):**

DESCRIPTION OF WHAT HAPPENED: (Brief description of the incident including the immediate actions and outcome. Objective information only)

IMMEDIATE ACTIONS AND OUTCOME:

WITNESS / PERSONS FAMILIAR WITH INCIDENT:

NAME: _____ **PHONE NUMBER:** _____

ADDRESS: _____

PATIENT OR NEXT OF KIN / GUARDIAN NOTIFIED? ☐ **Yes** ☐ **No** ☐ **N/A** **MEDICAL STAFF NOTIFIED?** ☐ **Yes** ☐ **No** ☐ **N/A**

SIGNATURE OF PERSON COMPLETING FORM:

PRINT NAME: **TITLE:**

DEPARTMENT: **PHONE NUMBER:**