To help us investigate your complaint/incident, please complete as much of the form as you can. If you need help completing the form contact patient services for assistance. If you cannot completed a section please put don’t know or not applicable.

You do not need to use this form to report an incident or complaint - talk to your clinic or patient services contact for further advice.

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| About You | | | | | |
| Patient details | | | | | |
| Patient *forename:* |  | | | NHS number: |  |
| Patient surname: |  | | | Hospital number: |  |
| Date of birth: |  | | | Carer’s name: |  |
| Ethnicity: | Choose an item. | | | Gender: | Male Female  Don’t know |
| Address: |  | | | | |
| Country: | England Northern Ireland Scotland Wales | | | | |
| Homecare provider: | | |  | | |
| Medicines delivered by homecare provider: | | |  | | |
| Diagnosis treated using medicines delivered by homecare provider: | | |  | | |
| Hospital prescribing medicines delivered by homecare provider: | | |  | | |
| Complaint/incident reporter details | | | | | |
| Relationship to patient / Reporter type: | | Choose an item. | | | |
| Name of reporter/person completing form: | |  | | | |
| Telephone: | |  | | | |
| Email: | |  | | | |
| Address: | |  | | | |

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| About the complaint or incident | | | | |
| Date complaint/incident occurred: | | |  | |
| Time complaint/incident occurred: | | |  | |
| Location incident occurred: | Home Setting Work School Care home  Nursing home Hospital Other: specify | | | |
| Date reported: |  | | Time reported: |  |
| Was the patient actually harmed? | | | Yes No Don’t know | |
| If yes, what was the harm and to what part of the body? | | |  | |
| In your opinion, was this event preventable? | | | Yes No Don’t know | |
| Describe what happened: *(Do not use any personal identifiable data here. Instead for example say the patient, the hospital nurse or the customer service agent)* | | | | |
| Personal identifiable information about the complaint/incident:  *(E.g. Hospital nurse = Jane Doe*  *Customer service agent = Joe Bloggs)* | | |  | |
| Where available, reference any evidence supporting the description of what happened: | | |  | |
| Immediate actions taken: | | |  | |
| Relevant medical history: | | |  | |
| For medical products - do you agree to be contacted by the manufacturer if they want more information? | | | Yes No | |
| We will talk to you to explain what happened and what we have done to stop similar incidents happening again in future. Do you also require a written response? | | | Yes No | |
| About the medicine(s) Where you have described a complaint or incident related to a medicine, please give details of the medicine(s) here | | | | |
| Medicine 1 | | | | |
| Approved medicine name (drug name): | | |  | |
| Proprietary medicine name (brand): | | |  | |
| Medicine manufacturer: | | |  | |
| Form: (e.g. table, pre-filled syringe) | |  | Strength: |  |
| Dose frequency: | |  | Route: (e.g. oral,  s.c. injection) |  |
| Batch number: | |  | Expiry date: |  |
| Is the medicine available for inspection? | | Yes No | If yes, where is the medicine now? |  |
| In your opinion how likely is this event due to the use of this medicine? | | | Very Unlikely  Unlikely | Likely  Very Likely |
| Please tell us about other medicines being taken at the same time: | | |  | |
| Medicine 2 | | | | |
| Approved medicine name (drug name): | | |  | |
| Proprietary medicine name (brand): | | |  | |
| Medicine manufacturer: | | |  | |
| Form: (e.g. table, pre-filled syringe) | |  | Strength: |  |
| Dose frequency: | |  | Route: (e.g. oral,  s.c. injection) |  |
| Batch number: | |  | Expiry date: |  |
| Is the medicine available for inspection? | | Yes No | If yes, where is the medicine now? |  |
| In your opinion how likely is this event due to the use of this medicine? | | | Very Unlikely  Unlikely | Likely  Very Likely |
| Please tell us about other medicines being taken at the same time: | | |  | |
| *If more than two medicines are to be reported, attach a separate sheet to this report form and reference it in the supporting documents field above* | | | | |

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| --- | --- | --- | --- |
| About the medical device(s) Where you have described a complaint or incident related to a medical device, please give details of the device(s) here | | | |
| Device 1 | | | |
| Name of medical device: |  | | |
| Model: |  | | |
| Manufacturer: |  | | |
| Catalogue number: |  | Serial number: |  |
| Supplier: |  | Batch Number: |  |
| Expiry date: |  | Date of manufacture: |  |
| Is the device available for inspection? | Yes No | If yes, where is the device now? |  |
| Device 2 | | | |
| Name of medical device: |  | | |
| Model: |  | | |
| Manufacturer: |  | | |
| Catalogue number: |  | Serial number: |  |
| Supplier: |  | Batch Number: |  |
| Expiry date: |  | Date of manufacture: |  |
| Is the device available for inspection? | Yes No | If yes, where is the device now? |  |
| *If more than two devices are to be reported, attach a separate sheet to this report form and reference it in the supporting documents field above* | | | |