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* |