TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER.
EL PASO

Confidential Peer Review

Non-Employee Occurrence Report

1. ∆ Treatment issue ∆ Slip/fall ∆ Communication ∆ Medication ∆ Medical Equipment ∆ Other

2. EXACT LOCATION OF OCCURRENCE:

____

Date of Occurrence:_______________________________Time of Occurrence: __________________

3. PERSON PREPARING REPORT:

Name:_________________________ Department:__________________ Phone: _______________

Date report prepared: ______________________________ Time report prepared: ______________

4. PERSON INVOLVED:

Name (last, first, m.i.) ____

Address: ____ Phone: ______________________

Medical Record Number (if applicable)____________________________DOB: __________________

Please **circle one** of the following, **and** indicate **which** clinic, school, destination or department:

Patient - Clinic: ________________________________

Student-School: ________________________________

Visitor – Destination: ___________________________

Volunteer – Department: _________________________

5. WITNESSES: ∆Yes ∆ No

Who:________________________________Contact #: _____________________________________

Is witness an employee? ∆Yes ∆ No Department: _____________________________

6. PROBLEM or ISSUE: Please describe exactly WHAT, WHY, HOW, (R) or (L) side of body, which finger, etc.

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7. FALLS:

Activity/circumstances of patient when fall occurred: _____________________________________

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Treatment given or action taken: ____

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8. Seen by Physician: ∆ Yes ∆ No

Physician assessment: ____

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Physician's Signature:___________________________Date: ______________________________

9. Disposition of patient/outcome: ____

Do Not Place in Medical Record

Submit to: Department of Safety Services- El Paso