TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER
School of Medicine™

Confidential Peer Review

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: ____

____

Treatment given or action taken: ____

____

8. Seen by Physician: ☐ Yes ☐ No

Physician assessment: ____

____

Physician's Signature: ___________________________Date: ________________________________

9. Disposition of patient/outcome: ____

Do not Place in Medical Record

Submit to: *Amarillo: QI/RM - B500;* *Lubbock: PI - STOP 6559;* *El Paso: Safety Manager;* *Odessa: QI/RM - 1C64*