TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER™

Occurrence Report

Confidential Peer Review

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: _____

4. PERSON INVOLVED:

Name (last, first, m.i.): _____

Address: _____ Phone: _____

Medical Record Number (if applicable)_____ DOB: _____

Please **select one** of the following, and indicate **which** clinic, school, 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.

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:

Submit to: Quality Improvement – A02