TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER™
School *of* Nursing

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.

_____

_____

_____

_____

_____

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

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