Patient Occurrence Report

This form is Property of* National Baromedical Services *and to remain Confidential

Patient Label

Date of Event:_____ Time of Event:_____
Location: _____ **Day of the Week:** Sun M T W TH F Sat *(circle one)*

☐Complication/Unexpected Clinical Effect

☐ Seizure (or premonitory s/s)
☐ Hypoglycemia
☐ Pulmonary Barotrauma
☐ Ear Barotrauma > Teed 2
☐ Loss of Airway
☐ Cardiac/Respiratory Arrest
☐ Injury to Organ/Bone/Skin
☐ Equipment Malfunction
☐ Loss of Oxygen
☐ Emergent Decompression
☐ Fire
☐ Other: _____

☐ IV/Blood/Medication

☐ Wrong Rate
☐ Wrong Patient
☐ Wrong Fluid/Medication
☐ Phlebitis
☐ Disconnection
☐ Infiltration
☐ Misread Order
☐ Wrong Time
☐ Wrong Dose
☐ Wrong Route
☐ Allergic Reaction
☐ Other: _____

☐ Equipment Involved _____ Model # _____ Serial #: _____ Inventory #: _____
Date of Last Bio Med Inspection Service: _____ Is Item Still In Service? ☐ Yes ☐ No

☐ Patient Fall

☐ From Stretcher
☐ From Chair/Toilet/Wheelchair
☐ To/From Bathroom/Dressing Room
☐ Slip/Trip
☐ Un-witnessed
☐ Witnessed
Mental Status Prior to Fall: ☐ Alert ☐ Disoriented ☐ Sedated ☐ Unconscious
Last Fall Risk Assessment (date/time): _____ Patient "Risk for fall"? ☐ Yes ☐ No
Other Details:_____

☞**Vital Signs at Time of Occurrence:** B/P: _____ P:_____ R:_____ T:_____ Pulse Ox:_____ Pain: ___out of 10
Diabetic: ☐ Yes ☐ No If Yes, Blood Glucose: Pre-Tx _____ Blood Glucose at Time of Occurrence: _____
EKG Alarms ☐ On ☐ Off Alarm Parameters _____ Printed Strip on Chart: ☐ Yes ☐ No
Relevant Medications? _____

?Patient Complaint(s): _____

✓Current Diagnosis: _____Any Head/Neck Radiation? ☐ Yes ☐ No

✓Current Treatment Protocol: _____ ATA Air Breaks? ☐Yes ☐No Tx#: _____ How Many Minutes into Treatment? _____

✓Brief Factual Description of Event *(Attach copy of progress and physician notes if needed):* _____

_____

_____

✓Patient Assessed by Physician: ☐ Yes ☐ No Witness: _____

✓Immediate Action *(e.g. Orders, Lab Tests, X-Ray, CT Scan, Medication, Dressing)*

_____

✓Extent of Injury: ☐ None ☐ Minor Injury ☐ Major Injury ☐ Unknown

✓Outcome Description: _____

_____

➪Report Completed By: _____ Date _____

➪Report Reviewed By Manager: _____ Date _____

➪Report Reviewed By Medical Director: _____ Date _____

For Corporate Use Only: *Form to be submitted to NBS Corporate within 72 hours of event.*
Vice President: _____ Date: _____ Corp Medical Director: _____ Date: _____
Action: ☐ File ☐ Safety Notice ☐Equipment Inquiry ☐ Entered into Database by: _____

FILL IN ALL APPLICABLE FIELDS - DO NOT STORE IN PATIENT CHART – CONFIDENTIAL

Revised 11/2011