Dental clinical incident report form

FORM TEMPLATE

Check this template against your local regulations and your own policies before you use it.

Name _____ Role _____ Date _____

* Required

Date of the incident *

_____

Patient file number *

Use the file number, not the name, so the report holds as little personal detail as it needs.

_____

Type of incident *

- ○ Wrong tooth or site
- ○ Allergic reaction
- ○ Swallowed or inhaled object
- ○ Medical emergency
- ○ Medication error
- ○ Near miss
- ○ Other

What happened *

Stick to the facts: what happened, in what order, and who was there.

_____

_____

_____

Harm to the patient *

- ○ None
- ○ Minor
- ○ Moderate
- ○ Major

What was done straight away *

_____

_____

_____

Was the patient told? *

- ☐ Yes
- ☐ No

What could stop it happening again

_____

_____

_____

Signature *

This report is true to the best of my knowledge.

Signature _____ Name _____ Date _____

For the reviewer

Reviewed by _____ Decision _____ Date _____ Notes _____