



Capital Health  
Risk Management & Patient Safety

**PATIENT SAFETY EVENT REPORT FORM**  
*FAMILY PRACTICE*

COMPLETE FOR HOSPITAL RELATED PATIENT SAFETY  
EVENTS IDENTIFIED POST DISCHARGE IN THE  
FAMILY PRACTICE SETTING

**CONFIDENTIAL**  
**DO NOT PHOTOCOPY or**  
**COPY TO PATIENT RECORD**

*Please Print Clearly*

**Patient's Name:**

Last: \_\_\_\_\_

First: \_\_\_\_\_

Initial(s): \_\_\_\_\_

D.O.B.: \_\_\_\_\_  
                    YYYY      MM      DD

Health Card Number:  
\_\_\_\_\_

**DISCHARGE FACILITY INFO:**

<ul style="list-style-type: none"> <li><input type="radio"/> Addiction Prevention &amp; Treatment Services</li> <li><input type="radio"/> Cobequid Community Health Centre</li> <li><input type="radio"/> Correctional Health Unit</li> <li><input type="radio"/> Dartmouth General Hospital</li> <li><input type="radio"/> East Coast Forensic Hospital</li> <li><input type="radio"/> Eastern Shore Memorial Hospital</li> <li><input type="radio"/> Environmental Health Unit</li> </ul>	<ul style="list-style-type: none"> <li><input type="radio"/> Hants Community Hospital</li> <li><input type="radio"/> Mental Health Program</li> <li><input type="radio"/> Musquodoboit Valley Memorial Hospital</li> <li><input type="radio"/> Public Health</li> <li><input type="radio"/> Queen Elizabeth II Health Sciences Centre</li> <li><input type="radio"/> Twin Oaks Memorial Hospital</li> <li><input type="radio"/> Other - Specify:</li> </ul>	<p>Floor/Clinic/Unit:</p> <hr/> <p>Date Discharged: <small>(yyyy mm dd)</small></p> <hr/> <p>Date Reported: <small>(yyyy mm dd)</small></p> <hr/>
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**MEDICATION-RELATED ISSUES:**

<ul style="list-style-type: none"> <li><input type="radio"/> Controlled Drug</li> <li><input type="radio"/> Dosage Strength</li> <li><input type="radio"/> Extra Dose</li> <li><input type="radio"/> Known Allergy</li> <li><input type="radio"/> Incomplete Prescription</li> <li><input type="radio"/> New Prescription &amp; Old Prescription Not Discontinued</li> <li><input type="radio"/> No Prescription</li> <li><input type="radio"/> Prescription Not Filled</li> <li><input type="radio"/> Route or Site</li> <li><input type="radio"/> Other - Specify:</li> </ul>	<p><b>Name(s) of Medication(s):</b></p> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>	<p><b>Comments:</b></p> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
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**OTHER ISSUES:**

<ul style="list-style-type: none"> <li><input type="radio"/> Communication</li> <li><input type="radio"/> Contributing Patient Factors</li> <li><input type="radio"/> Discharge Preparation</li> <li><input type="radio"/> Follow-up</li> <li><input type="radio"/> Post Discharge Complication</li> <li><input type="radio"/> Procedure Related</li> <li><input type="radio"/> Other - Specify:</li> </ul>	<p><b>Comments:</b></p> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
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**FAX TO 464-4811**  
**Attention: CDHA Risk Management & Patient Safety**