



NIAIC ADVERSE INCIDENT REPORT FORM

Details of the report: Reporting Body: Address : Post Code : Reporter : Position : Tel No : Email : Date : Trust / Datix Ref:	Location of the incident: As Reporter : <input type="checkbox"/> Facility/Building: Ward/Dept : Local Contact for Further Details: Position : Email : Tel No :
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Details of device:			
Manufacturer		Catalogue No	
Type of Product		Serial No	
Model			
Supplier			
Batch / Lot No		Date of mfr	
Quantity Defective		Expiry date	
CURRENT LOCATION OF DEVICE			
Has the manufacturer already collected the device? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes please supply their contact details:			

Incident details MUST NOT contain any patient identifiable data	Severity of Injury:
Injury details: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

Date of Incident:

Details of defect / incident:

Action taken by staff :

The above data shall be handled in accordance with our [Privacy Notice](#)