

NIAIC ADVERSE INCIDENT REPORT FORM

Please tick () the appropriate boxes

Origin of report:

Reporting Body: _____
 Address : _____

 Reporter : _____
 Position : _____
 Email : _____

This report confirms a telephone report a fax report neither

Type of device: (tick one only)

- | | | |
|--|---|---|
| <input type="checkbox"/> Active implantable devices | <input type="checkbox"/> External defibrillators & pacemakers | <input type="checkbox"/> Physiotherapy equipment |
| <input type="checkbox"/> Administration & giving sets | <input type="checkbox"/> Feeding tubes | <input type="checkbox"/> Radiotherapy equipment |
| <input type="checkbox"/> Anaesthetic machines & monitors | <input type="checkbox"/> Gloves | <input type="checkbox"/> Radionuclide equipment |
| <input type="checkbox"/> Anaesthetic & breathing masks | <input type="checkbox"/> Guidewires | <input type="checkbox"/> Resuscitators |
| <input type="checkbox"/> Autoclaves | <input type="checkbox"/> Hearing aids | <input type="checkbox"/> Staples & staple guns |
| <input type="checkbox"/> Bath aids | <input type="checkbox"/> Hypodermic syringes & needles | <input type="checkbox"/> Stretchers |
| <input type="checkbox"/> Beds, mattresses & cotsides | <input type="checkbox"/> Implant materials | <input type="checkbox"/> Surgical instruments |
| <input type="checkbox"/> Blood pressure measurement | <input type="checkbox"/> Infant incubators | <input type="checkbox"/> Surgical power tools |
| <input type="checkbox"/> Breast implants | <input type="checkbox"/> Infusion pumps, syringe drivers | <input type="checkbox"/> Sutures |
| <input type="checkbox"/> Cardiovascular implants & devices | <input type="checkbox"/> Insulin syringes | <input type="checkbox"/> Thermometers |
| <input type="checkbox"/> Commodes | <input type="checkbox"/> Intravenous catheters & cannulae | <input type="checkbox"/> Ultrasound equipment |
| <input type="checkbox"/> Contact lenses & care products | <input type="checkbox"/> Joint prostheses | <input type="checkbox"/> Urinary catheters |
| <input type="checkbox"/> CT systems | <input type="checkbox"/> Lasers & accessories | <input type="checkbox"/> Ventilators |
| <input type="checkbox"/> Dental materials & appliances | <input type="checkbox"/> Magnetic resonance equipment & accessories | <input type="checkbox"/> Walking sticks / frames/ aids for daily living |
| <input type="checkbox"/> Dialysis equipment | <input type="checkbox"/> Mobile x-ray systems | <input type="checkbox"/> Wound drains |
| <input type="checkbox"/> Diathermy equipment & accessories | <input type="checkbox"/> Monitors & electrodes | <input type="checkbox"/> X-ray equipment, systems & accessories |
| <input type="checkbox"/> Dressings | <input type="checkbox"/> Non-active implants | <input type="checkbox"/> Other (please specify) _____ |
| <input type="checkbox"/> Endoscopes & accessories | <input type="checkbox"/> Ophthalmic equipment | |
| <input type="checkbox"/> Endotracheal tubes & airways | <input type="checkbox"/> Patient hoists | |
| <input type="checkbox"/> Enteral feeding systems | <input type="checkbox"/> Patient monitoring equipment | <input type="checkbox"/> Estates Equipment |

Further details can be given on additional sheets if necessary

MEDICAL DEVICES

Details of device:

Product	_____	Catalogue No	_____
Model	_____	Serial No	_____
Manufacturer	_____		
Telephone no:	_____		
Supplier	_____		
Batch No	_____	Expiry date	_____
Date of mfr	_____	Quantity defective	_____
Location of device now	_____		

Is there a CE-mark? YES NO If YES, was the manufacturer or supplier contacted? YES NO

Was there a fatality? YES NO Was an injury caused? YES NO

Injury details:

Nature of defect / details of incident:

Contact for further details	_____		
Telephone number	_____	Email	_____

Action taken by staff / manufacturer / supplier:

PLEASE NOTE IT IS ILLEGAL TO SEND CONTAMINATED ITEMS THROUGH THE POST.
If you still have the incident device please retain it and await further instructions from the NIAIC.

Signed _____ Date _____ Your Ref _____

Please send completed form to: Northern Ireland Adverse Incident Centre, Health Estates, Stoney Road, Dundonald, BT16 1US, Fax 028 90523900, e-mail niaic@dhsspsni.gov.uk