ADVERSE EVENT REPORT

(Reporting of Adverse Events affecting patients managed within compensation systems)

PATIENT DETAILS

NAME	
DATE OF BIRTH	
EMPLOYER	
OCCUPATION	
INSURER/CLAIMS ADMINISTRATOR	
CLAIM NUMBER	
NATURE OF CLAIMED INJURY/DISEASE	

DESCRIPTION OF ADVERSE EVENT

EVENT DATE	
EVENT DETAILS	
POTENTIAL CONSEQUENCES	

ADVERSE EVENT CATEGORY (MARK APPROPRIATE CATEGORY)

MEDICAL MANAGEMENT	
REHABILITATION	
EMPLOYMENT	
CLAIMS MANAGEMENT	
OTHER (PLEASE SPECIFY)	

ACTION TAKEN

DATE OF ACTION	
DETAILS OF ACTION TAKEN	

REPORT DISTRIBUTION (INCLUDE NAME OF CONTACT)

PATIENT	
WORKPLACE REHABILITATION PROVIDER	
EMPLOYER	
INSURER/CLAIMS MANAGER	
WORKCOVER TASMANIA/MAIB/COMCARE	
OTHER (SPECIFY)	
COMMENTS	

PATIENT CONSENT

PATIENT SIGNATURE	

REPORT PREPARED BY

NAME OF DOCTOR	
CONTACT TEL	
DATE	