PARAMEDIC

West Midlands Ambulance Service NHS
NHS Trust

CRF05: Event Form

March 2012 Version 2.0

Please fax [redacted] *or email* [redacted]

within 24hrs of notification of event

Event affecting patient ☐ ***Event affecting crew*** ☐

1. Event Details *(Complete as applicable)*:

Date of Event *(dd/mm/yyyy)*		Device serial No			
Crew IDs/names:		Station Name:		Vehicle Call Sign:	
Date of cardiac arrest: *(dd/mm/yyyy)*		Case No:		Patient DoB *(dd/mm/yyyy)*	

2. Description of Event
(Please continue on separate sheet as necessary)

3. Follow up Information

Resolved? Y ☐ **N** ☐ Date resolved _____

4. Reason for Reporting *(all patients in this trial will be in an immediately life threatening situation; death or hospitalisation is certain. The options below should only be ticked if they were clearly caused by the event.)*

Death	Y ☐	N ☐
Life-threatening event	Y ☐	N ☐
In-patient hospitalisation or prolongation of existing hospitalisation	Y ☐	N ☐
Persistent or significant disability/incapacity	Y ☐	N ☐
Other medically significant reason for reporting	Y ☐	N ☐

If other please specify……..

Notified by *(signature)* _____ **Print Name** _____

Date of Report *dd/mm/yyyy*

OFFICE USE ONLY

Event No: _____

Was the event an ADE	**Yes** ☐	**No** ☐		
Was the event an SADE?	**Yes** ☐	**No** ☐	**Was the event related?**	**Yes** ☐ **No** ☐
Was the event an Incident?	**Yes** ☐	**No** ☐	**Was the event unexpected**	**Yes** ☐ **No** ☐
Checked by clinical reviewer:			**Device Failure?**	**Yes** ☐ **No** ☐
Date of review:			**User error?**	**Yes** ☐ **No** ☐