Incident Report Form

*** CONFIDENTIAL ***

Incident Report Number:	4163-005	**Printed:**	08/10/2016
Log As:	On-Site Investigation	**Page**	1 of 3
Date Reported:	08/28/2008	**Date of Incident:**	08/ /2008
Date Submitted:	06/22/2011	**Time of Incident:**	:

FACILITY INFORMATION

Facility:	Planned Parenthood Leag Ma Cnt Ma C (4163) 470 Pleasant Street Worcester, MA 01609	**ID:** **Type:** **Facility Reported:**	4163 Clinic Form No

INCIDENT INFORMATION

Incident/Allegation Type(s):	Quality of Care/Treatment-Oth	**Type of Harm(s):**	Quality of Care
Incident/Allegation Type(s) (after DPH review):	Quality of Care/Treatment-Oth	**Type of Harm(s) (after DPH review):**	Quality of Care
SRE Category(s):	Non-SRE		
SRE Category(s) (after DPH review):	*Non-SRE		
Body Part Affected(s):	Psychological	**Patient's Activity:**	
Location:	A	**Equipment in Use:**	
Safety Precaution(s):			

INCIDENT NARRATIVE

Complainant report: It is reported that the Patient had taken an at the Clinic. The Patient was informed that the is not 100% effective. The patient was informed that an immediate procedure would be performed if a was positive at the next visit. The Patient returned to the Clinic for the scheduled follow-up visit. A vas not given. A was performed. The Patient was informed that and everything was perfect. The Clinic prescribed which the Patient began taking immediately. Two weeks later, the Patient went to the emergency room due to The Patient was informed she was . It is reported that the emergency room doctors were shocked that had been performed at the Clinic. On-site.

CORRECTIVE MEASURES

Internal Investigation?:

Internal Investigation Narrative:

Corrective Measures Narrative:

FOLLOWUP INFORMATION

NOTIFICATIONS

Family: No **Police:** **Physician:** No

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Individual in Charge at Facility: **Title:** **Directly Involved?:**

REPORTER INFORMATION

Reporter: **Title:**

PATIENT INFORMATION

First Name	Last Name	Age	Gender	Admission Date	Ambulatory Status	ADL Status	Cognitive Level	Developmentally Disabled

PATIENT ADDRESS

First Name	Last Name	Address 1	Address 2	City	State	Zip Code

Physician Name (if notified):

ACCUSED INFORMATION

First Name	Last Name	Gender	Title	Hire Date

WITNESS INFORMATION

First Name	Last Name	Title	Directly Involved

END OF REPORT