Incident Report Form

*** CONFIDENTIAL ***

Incident Report Number:	44H1-002	**Printed:**	08/10/2016
Log As:	Refer to Other Agency	**Page**	1 of 3
Date Reported:	10/05/2005	**Date of Incident:**	10/04/2005
Date Submitted:	06/22/2011	**Time of Incident:**	33:30

FACILITY INFORMATION

Facility:	Four Women (44H1) 150 Emory Street Ground Floor Attleboro, 02703	**ID:** **Type:** **Facility Reported:**	44H1 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):		**Patient's Activity:**	Other, Unknown
Location:	A	**Equipment in Use:**	
Safety Precaution(s):			

INCIDENT NARRATIVE

Complainant's Letter: The Complainant is very frequent and has complained about several other related (Planned Parenthood) facilities. Complainant is advocating and alleging several issues: 1)with this facility's advertisement in the Yellow Pages as they advertise themselves as "safe," yet allegedly, it was not safe for one of their other patients. The Complainant is now questioning whether any Federal Regulations have been violated by this facility because of a malpractice suit by one of their patients.
CAS See other Incidents: #4132-1 (Planned Parenthood League of Mass.); #4163 (Planned Parenthood League of Mass. - Worcester); #4174-2 (Planned Parenthood/Preterm Health - Boston); #4350 (Eastern Health Centers - Methuen). CAS
*Referring over to the Mass. Board of Registration in Medicine (BORM) for their attention.

CORRECTIVE MEASURES

Internal Investigation?:

Internal Investigation Narrative:

Corrective Measures Narrative:

FOLLOWUP INFORMATION

NOTIFICATIONS

Family: Yes **Police:** **Physician:** Yes

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

REPORTER INFORMATION

Reporter: **Title:** Patient/Resident/Consumer

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