



COLLEGE OF NATUROPATHIC PHYSICIANS OF BRITISH COLUMBIA

CRITICAL INCIDENT REPORT

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| A. Patient Information (See "Confidentiality" section below) | |
| 1. Identifier: 2. Age at time of reaction: | 3. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female 4. Height ___ feet or ___ cm 5. Weight ___ lbs or ___ kgs |
| B. Adverse Reaction | |
| 1. Outcome attributed to adverse reaction (check all that apply) | |
| <input type="checkbox"/> Life-threatening <input type="checkbox"/> Hospitalization <input type="checkbox"/> Disability <input type="checkbox"/> Required intervention to prevent damage / permanent impairment <input type="checkbox"/> Death _____ (dd / mm / yyyy) <input type="checkbox"/> Other: _____ | 2. Date of reaction (dd/mm/yyyy): 3. Date of this report (dd/mm/yyyy): 4. Presenting Symptoms: |
| 4. Describe reaction or problem Examples Anaphylaxis, Seizure, Myocardial Infarction, Other which results in CPR and/or EMERGENCY 9/11 call | |
| 5. Relevant tests / laboratory data (including dates (dd / mm / yyyy)) | |
| 6. Other relevant history, including pre-existing medical conditions (e.g. allergies, pregnancy, smoking and alcohol use, hepatic / renal dysfunction) | |
| C. Suspected Health Products or Suspected Procedure performed (See "How to report " section below) | |
| Name (give labelled strength & manufacturer, if known) List <u>all</u> Products &/ Procedures suspect | |
| #1 _____ #2 _____ | |
| 2. Dose, frequency & route used #1 _____ #2 _____ | 3. Therapy dates (if unknown, give duration) From (dd / mm / yyyy) - To (dd / mm / yyyy) |
| 4. Indication for use of suspected health product/procedure #1 _____ #2 _____ | 5. Reaction abated after use stopped or dose reduced #1 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't apply #2 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't apply |
| 6. Lot # (if known) #1 _____ #2 _____ | 8. Reaction reappeared after use stopped or dose reduced #1 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't apply #2 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't apply |
| 7. Exp. date (if known) (dd/mm/yyyy) #1 _____ #2 _____ | |
| 9. Other Supplements taken (name, dose, frequency and route used) and/or Other Treatments used (dd / mm / yyyy) | |
| 10. Treatment of adverse reaction (medications and / other therapy), include dates (dd/mm/yyyy) | |
| D. Reporter Information (See "Confidentiality" section below) | |
| 1. Name, address & phone number | |
| <p>Submission of a report does not constitute an admission that medical personnel or the product caused or contributed to the adverse reaction. * Use this form to report suspected adverse reactions to any naturopathic treatments or natural health products that your patient experiences in your presence at your practicing Clinic. ** This form is not to replace the form collected by Canadian Adverse Drug Reaction Monitoring Program (CADRMP). Attach sheets if additional space is required. LReturn this form to the College of Naturopathic Physicians of BC.</p> | |