PHYSICIANS INDEMNITY RISK RETENTION GROUP

Confidential Incident Report form

Physician's Name: ____ ____________________

Home Address: ____

Home Phone: ________________ **Work Phone:** ________________ **Cell Phone:** _______________

Facility Where Incident Occurred: ____

Dates of Treatment: ____

Name of Patient: _______________________________ **Sex:** _____ **DOB:** __________

Medicare Recipient? ☐ **No** ☐ **Yes ID#** _________________ **Social Security #**_______________

Married: ______ **Divorced:** _______ **Single:** ______

Incident Description (include symptoms, nature of care provided, final outcome):

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Names of other healthcare providers involved: ____

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Any known hostility or threats of litigation by patient or friends? (If so explain)

____

Have you received a claim notice letter or lawsuit? Yes/No (If yes, immediately forward all documents, including any medical records to Physicians Indemnity Risk Retention Group with this report)

If a claim letter or lawsuit was received, please enter the date: _____________________

Completed by: ________________________________ **Date:** _________________________

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