**MISADMINISTRATION/RECORDABLE EVENT REPORT**

 Therapeutic Diagnostic Other

**PATIENT DATA**

|  |  |
| --- | --- |
| Name of Physician |  |
| Name of Allied Health Personnel  |  |
| Name and Medical Record # of Patient |  |
| Name of Patient's Referring Physician |  |

**DESCRIPTION OF THE EVENT** (include dates and times)

|  |
| --- |
|  |

**EFFECT ON THE PATIENT**

|  |  |
| --- | --- |
|  **TARGET ORGAN** |  **ESTIMATED RADIATION DOSE** |
|  |  |
|  |  |
|  |  |
|  |  |

**ACTIONS TAKEN TO PREVENT RECURRENCE**

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|  |

The report is prepared in accordance with the regulations in COMAR 26.12.01.01, Sec D.1209.

Prepared by Date

Reviewed and Approved by Date