

# Incident/accident reporting

## Pharmacy compounding of non-sterile preparations

Reporting an  incident  accident

Date of incident/accident:

*(dd/mm/yy)*

Time of incident/accident:

Reported by:

Name of patient affected, if applicable:

Full address:

Phone number:

Pharmacy personnel involved:

Information about incident/accident:

Disclosed to the patient concerned:  Yes Name of pharmacist following up:

### Analysis of causes

Causes:

Options for corrections  
or changes:

Corrections or changes  
chosen:

## Action plan

Actions:

Responsible:

Deadline:



## Monitoring

Verifications:

Responsible:



## Closing of the file

Signature of pharmacist responsible for follow-up:

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