Diagnostic Radiation Event Record

FORM 17

Facility Name: _____ **Period(s) or Date(s):** _____ **Sheet:** _____

INTERNAL RECORD - retain names here; prepare external reports according to the applicable disclosure rules.

Event or Discovery Date And Time: _____ **Unit or Event Reference:** _____

Patient Name or ID: _____

Prescribing Physician: _____ **Referring Physician:** _____

Other Individuals Involved (names or Roles; Attach Continuation If Needed):

Description Of Event And Investigation Of Cause:

Effect On Patient or Assessment And Supporting Clinical Reference:

Improvements Needed And Actions Taken To Prevent Recurrence:

Diagnostic Radiation Event Record

FORM 17

Facility Name: _____ **Period(s) or Date(s):** _____ **Sheet:** _____

Record supporting references, review, and applicable requirements below.

Note(s) or Supporting Record(s):

Investigator or Date: _____ **RSO or Reviewer or Date:** _____

State or Jurisdiction: _____

Regulatory Requirement Reference(s): _____

Required Interval(s) or Deadline(s): _____

Retention(s) or Trigger(s): _____