REPORTING A TIER 1 EVENT

TIER ONE EVENTS:

Serious adverse events must be reported to the RCDSO in writing within 24 hours of knowledge of the event.

- Death of a patient within the facility.
- Death of a patient within 10 days of a procedure performed at the facility.
- Transfer of a patient from the facility directly to a hospital for care.

1. COMPLETION OF REPORT

NAME OF PERSON COMPLETING THIS REPORT:

TITLE:

TELEPHONE:

DATE REPORT COMPLETED:

2. GENERAL INFORMATION

SEDATION FACILITY PERMIT HOLDER:

FACILITY ADDRESS:

DENTAL TREATMENT PERFORMED BY:

DATE OF THE INCIDENT: DAY: MONTH: YEAR:

SEDATION PERFORMED BY:

LEVEL OF SEDATION INTENDED AND MODALITY:

3. PATIENT INFORMATION

PATIENT IDENTIFICATION NUMBER (IF APPLICABLE):

PATIENT NAME:

HT: WT: GENDER: ☐ MALE ☐ FEMALE AGE:

DATE OF BIRTH:

ASA CLASSIFICATION:

TREATMENT PROPOSED:

TREATMENT PERFORMED:

DESCRIPTION OF COMPLICATION, PATIENT STATUS, AND DISPOSITION OF INCIDENT:

For each section: Please answer using the space provided **OR** if more space is required, attach a WORD file, appropriately named.

1. PRE OP *(check one)*

☐ **Please see my attached WORD file, named "1. Pre Op description"**

☐ **Pre Op description:**

2. INTRA OP *(check one)*

☐ **Please see my attached WORD file, named "2. Intra Op description"**

☐ **Intra Op description:**

3. POST OP *(check one)*

☐ **Please see my attached WORD file, named "3. Post Op description"**

☐ **Post Op description:**

Patient transfered to hospital: ☐ YES ☐ NO

Name of hospital:

4. SUBMISSION OF TIER REPORT FORM

Tier report forms must be submitted through the College's secure email system.

To access the secure email system and submit the form, contact eventreports@rcdso.org to request a secure email link.

Once you receive the secure email link, log in to your secure email to respond to the email with the following documentation:

1. completed Tier Report form (including any additional WORD files)
2. a copy of the related sedation or anesthesia record (if applicable)
3. the patient's medical history review documentation

You may also include related clinical notes.

DENTIST WHO PROVIDED TREATMENT OR SEDATION PROVIDER - I HAVE REVIEWED THE CONTENTS OF THIS REPORT:
SIGNATURE:
DATE:
PRINTED NAME:

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