BCCOHP | British Columbia College of Oral Health Professionals

Mailing Address
110 - 1765 8th Ave W
Vancouver, BC V6J 5C6

Phone: 672.202.0448
Toll free: 1.888.202.0448
www.oralhealthbc.ca

CRITICAL INCIDENT REPORT FORM

The attending dentist shall notify the Registrar of the BC College of Oral Health Professionals (BCCOHP) within one working day after the discovery of any significant incident or issue, including:

- Deaths within 10 days of the procedure;
- Transfers from the facility to a hospital regardless of whether or not the patient was admitted; or
- Unexpected admission or presentation to hospital within 10 days of a procedure or anesthetic performed in the facility.

Initial contact with the Registrar shall be made by phone within one working day and be followed up by a complete written **report by the attending dentist**. The Registrar will review the circumstances and may consult with the dentist or other practitioners to determine the risk of harm to patients. If necessary, the Registrar, acting in consultation with the Sedation and General Anesthesia Committee, may suspend the accreditation of any facility on a suspicion of continuing risk.

BCCOHP Registrar Contact Information Phone: 672-202-0448

Registrar notified (M/D/Y) _____

Type of Incident

☐ Death within the facility or within 10 days of the procedure

☐ Transfers from the facility to a hospital* regardless of whether or not the patient was admitted

☐ Unexpected admission or presentation to hospital* within 10 days of a procedure or anesthetic performed in the facility

*Hospital name _____

Attending Dentist _____ Registration Number _____

Address _____

City/Province _____ Postal Code _____

Date of Treatment (M/D/Y) _____

Procedure performed _____

Practitioner Administering Sedation (if applicable) _____ Phone _____

Address _____

City/Province _____ Postal Code _____

Name of Facility _____ Phone _____

Address _____

City/Province _____ Postal Code _____

Facility Owner(s) _____

Patient _____ Phone _____

Address _____

City/Province _____ Postal Code _____

Date of birth (M/D/Y) _____ Gender ☐ female ☐ male ☐ other: _____

Email address _____

Brief summary of incident

Present patient status

Additional details of note

If you have any questions about the collection and use of this information, please contact BCCOHP at 110-1765 West 8th Ave, Vancouver, BC V6J 5C6 or by phone at 672-202-0448.

Required Documentation

Please confirm that the following required documentation is being provided to BCCOHP:

☐ A narrative summary **by the dentist most involved with the case**, describing the incident, risk factors, outcome, and how it might be prevented in the future

☐ A copy of the patient's **full clinical record**, including medical history, from this facility