# INCIDENT INTAKE FORM

| Contact Information | | |
|---|---|---|
| Received By: | Date Received: | Location: |
| Reported By: | Reporting Organization: | |
| Organization Telephone No.: | Organization Address: | |
| Incident Date(s): | Surgeon: | |
| Contact Person(s): | Contact Phone:<br>E-Mail: | |

**Product / Service Information**

**Is feedback related to customer service?** ☐ **Yes** ☐ **No (If Yes, do not proceed. Notify Customer Service as this feedback does not meet the definition of Complaint)**

Service(s): ☐ Delivery ☐ Pricing ☐ Order Processing ☐ Invoicing ☐ Other:

**Is feedback related to product?** ☐ **Yes** ☐ **No If "Yes" assign Complaint #** ____________________________

**Product(s):** ☐ Skin ☐ MS ☐ Ocular ☐ Other:

| Tissue ID: | Description: |
|---|---|
| Tissue ID: | Description: |
| Tissue ID: | Description: |
| Tissue ID: | Description: |

Are product(s) to be returned**?** ☐ No ☐ Yes Return Goods Authorization (RGA) Number: _________

**Incident Summary**

Incident Narrative:

| Was there an injury to the patient or user?<br>☐ No ☐ Yes (If Yes, Explain in narrative section) | Was surgical intervention required to prevent permanent impairment of a body function or permanent damage to a body structure?<br>☐ No ☐ Yes (If Yes, Explain in narrative section) |
|---|---|
| Was there a deviation from applicable regulations that relate to the prevention or communicable disease transmission or HCT/P contamination?<br>☐ No ☐ Yes (If Yes, Explain in narrative section) | Was there an unexpected incident that may relate to the transmission or potential transmission of a communicable disease or may lead to HCT/P contamination?<br>☐ No ☐ Yes (If Yes, Explain in narrative section) |

| **Incident Evaluation / Disposition (Quality Assurance)** | |
|---|---|
| Based upon review of the information provided, does the information received meet the definition of a: | |
| ☐ Adverse Reaction | Complaint #(s) ________________ |
| ☐ HCT/P Deviation | Complaint #(s) ________________ |
| **Signature:** | **Date:** |