



## The College of Naturopaths of Ontario

Type 2 occurrences are to be reported to the College annually by the designated Registrant. Prior to the reporting date the designated Registrant will be notified as to how and in what format the information is to be provided to the College.

**This tracking form is a tool that may be used by all Registrants at a premises to record and track the Type 2 occurrences that happen throughout the year. This form is not to be submitted to the College.**

It is recommended that the form be kept in the patient's file as well as a master file at the premises.

Type 2 occurrences as defined in the General Regulation are:

- Any infection occurring in a patient in the premises after a procedure was performed at the premises.
- An unscheduled treatment of a patient by a Registrant occurring within five days after a procedure was performed at the premises.
- Any adverse drug reaction occurring in a patient after a procedure was performed at the premises.

An adverse drug reaction is defined as a harmful and unintended response by a patient to a drug or substance or combination of drugs or substances that occurs at doses normally used or tested in humans for the diagnosis, treatment or prevention of a disease or the modifications of organic function.

### Type 2 Occurrence Tracking Form

#### 1. Type of Occurrence

- ☐ An infection occurred in a patient after a procedure was performed at the premises.

Type of infection: \_\_\_\_\_

- ☐ An unscheduled treatment of a patient by a Registrant occurred within five days after a procedure was performed at the premises.

Type of treatment: \_\_\_\_\_

- ☐ An adverse drug reaction occurred in a patient after a procedure was performed at the premises.

Description of the adverse reaction: \_\_\_\_\_

2. Premises Information		
Clinic name where the occurrence happened:		
Street Address:		
City:	Postal Code:	Date (mm/dd/yyyy) of occurrence:
3. Patient Information		
Patient initials:	Date of birth (mm/dd/yyyy):	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>
4. Reporting Registrant Information		
Last Name:	First Name:	Registration #:
Practice Address:		
City:	Province:	Postal Code:
Telephone:	Email:	
5. Treating Registrant Information		
Contact information of the ND who was treating the patient, if different from above.		
Last Name:	First Name:	Registration #:
Practice Address:		
City:	Province:	Postal Code:
Telephone:	Email:	
6. Treating Staff		
Names of all staff, this includes Naturopathic Doctors, registered health care practitioners (HCP) and non-registered health care practitioners (non-HCP), who were directly involved with providing care for the patient.		
Last Name:	First Name:	

HCP <input type="checkbox"/> College:	
Non-HCP <input type="checkbox"/>	
Last Name:	First Name:
HCP <input type="checkbox"/> College:	
Non-HCP <input type="checkbox"/>	
Last Name:	First Name:
HCP <input type="checkbox"/> College:	
Non-HCP <input type="checkbox"/>	
Last Name:	First Name:
HCP <input type="checkbox"/> College:	
Non-HCP <input type="checkbox"/>	
Last Name:	First Name:
HCP <input type="checkbox"/> College:	
Non-HCP <input type="checkbox"/>	
<b>7. Witnesses</b>	
Names of all those who witnessed the occurrence.	
Last Name:	First Name:
Last Name:	First Name:
Last Name:	First Name:
Last Name:	First Name:
Last Name:	First Name:

## 8. Occurrence Information

Details relevant to the occurrence, including events leading up to the occurrence, treatments given before, during and after the occurrence, other actions taken and the outcome.

## 9. Declaration and Signature

I hereby declare that, to the best of my knowledge, the information on this form is true and complete. I understand and agree that it is professional misconduct to make a false or misleading statement.

Name:

Signature:

Date:

☐ Please check this box if you are completing this form electronically. This represents your signature.