

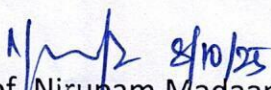
ALL INDIA INSTITUTE OF MEDICAL SCIENCES
ANSARI NAGAR, NEW DELHI-110029

No.F.35/Store/2025-Estt.(H)

Dated : 08.10.2025

Sub.: Reporting format for issues related to hospital stores – reg.

Numerous complaints regarding the quality of drugs and medical devices are circulating on WhatsApp. In order to document and Institute necessary administrative/corrective measures, all concerned are requested to provide details in the enclosed format to the office of the Medical Superintendent.


(Prof. Nirupam Madaan)
Medical Superintendent

Distribution :

- 1) Chief of all Centre(s)
- 2) Heads of all Department(s)
- 3) PIC-Procurement
- 4) All Sr. Stores Officer(s)/Store Officer(s)/Asstt. Store Officer(s)
- 5) Sr. FA/FA
- 6) Chief Nursing Officer/All NS/DNS/ANS/Nursing Staff
- 7) PIC(CF) - with the request to kindly upload it on the AIIMS content provider

Copy to: Nodal Officer - Patient Safety/Quality

C.C.: Director/ADA AIIMS - for information please.

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Quality & Patient Safety Cell

Incident Reporting Form

Note:

- The process is strictly non-punitive to encourage transparent and timely reporting for continuous improvement.
- The purpose of incident reporting is for system improvement and enhancing patient safety and quality of care.

Date of Incident :

Time of Incident :

Location of Incident (Ward/Department) :

Brief description of incident :

(Provide a detailed summary of what occurred, including the sequence of events)

Drug*		Medical Device/Equipment*	
Quality related issues	<input type="checkbox"/>	Device Malfunction	<input type="checkbox"/>
Packaging issues	<input type="checkbox"/>	Leakage	<input type="checkbox"/>
Expired drugs	<input type="checkbox"/>	Obstruction/Occlusion	<input type="checkbox"/>
Others:	<input type="checkbox"/>	Dislodgment	<input type="checkbox"/>
		Others:	<input type="checkbox"/>

***Supporting Sample/Item :**

(Please submit any relevant sample/item related to the incident)

Name of item/drug/device	Model/Serial No./Batch No., Mfg. and Exp. Date	Name of manufacturer & address

Supporting Documents/Photos (optional) :

(Please attach any relevant documents related to the incident)

Name, Designation and Signature of the healthcare personnel reporting the incident

(Optional):

Place :

Date :