



Regional MDR Recall of Goods and Tracking Form

BTHC BRHC PRHC CMH HSAH

Recall initiated: Date: _____ Time: _____

Department & Person that issued the recall: _____

Departments involved in the recall:	Persons notified, title, and clinical area:
Reason for recall:	Load Identification:
Corrective action(s) taken (i.e., followed full reprocessing process):	
Description and ID number of equipment taken <u>out of service</u> (if applicable):	
Number of items recalled: _____	Number of items retrieved: _____
Number of items not retrieved: _____	List of items retrieved: See page 2
List items not retrieved: Explanation of non-retrieval:	
Action(s) to prevent recurrence and improve recall process:	
Safety Event Report initiated: <input type="checkbox"/> Yes <input type="checkbox"/> No	

Notes: _____



Regional MDR Recall of Goods and Tracking Form

BTHC BRHC PRHC CMH HSAH

Quantity	Description of items retrieved	Dept