CNAO Centro Nazionale di Adroterapia Oncologica	REPORTING - PATIENT CLAIM N°:	Mod. 007 rev.5
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Please submit this form to the Reception or send it by e-mail to: comunicazione@cnao.it

PATIENT NAME and SURNAME			DATE
SEX	**AGE**	**NATIONALITY**	**EDUCATION**
☐ MALE ☐ FEMALE		☐ ITALIAN ☐ EUROPEAN ☐ EXTRA-EUROPEAN	☐NONE ☐COMPULSORY SCHOOL ☐HIGH SCHOOL ☐DEGREE
E-MAIL ADDRESS		**TELEPHONE NUMBER**	

CLAIM DESCRIPTION (to be filled in by the person recording the claim)				
Date:	**Consent for processing collected data**	**YES** ☐	**NO** ☐	**Signature:**

According to the European Regulation UE 2016/679 we point out that information reported in this module are confidential and used for the user who reports the claim. The lack of consent to the processing of personal data will prevent any answers to this claim.

ANALYSIS OF THE CAUSES GIVING RISE THE CLAIM		CORRECTIVE ACTION/ PREVENTIVE ACTION
Date:	**Signature:**	

ACTIONS FOR SOLVING THE CLAIM		
ACTIVITIES	PERSON IN CHARGE	DEADLINE
Date:	**Signature:**	

CLAIM SOLVING	
Date:	**Signature:**

CLOSURE OF THE CLAIM TO BE VERIFIED BY THE PERSON IN CHARGE OF THE QUALITY MANAGEMENT SYSTEM		
AC/AP:	DATE:	SIGNATURE (QM):