# SWNODN RISK IDENTIFICATION FORM

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| --- | --- |
| Risk / Issue reported by:Name:  | Date:  |
| Designation:  | Trust:  |
| Please complete the following in describing the risk:There is a risk that …..This is caused by ……..Would lead to an impact/effect on …..  |
| When is this risk likely to occur?[ ]  0 – 3 months[ ]  3 – 6 months[ ]  6 – 9 months[ ]  9 – 12 months[ ]  12 + months | Speciality Area of risk: (ie, respiratory, cardiology, SWNODN wide) |
| What control measures are in place locally? |
| Contacts at location of risk: |
| Trust Risk Lead: | Name: |  |
| Job Title |  |
| E-mail: |  |
| Risk Owner: | Name: |  |
| Job Title |  |
| E-mail: |  |
| SWNODN Management Office: |
| Date received by SWNODN Office: |  |
| Date added to SWNODN Risk Register |  |
| SWNODN Risk Ref No:  |  |

Please e-mail this form to joanne.smart@nbt.nhs.uk

Any queries, please call 0117 41 41184 or 41185