PATIENT / EMPLOYEE OCCURRENCE / INCIDENT REPORT

CONFIDENTIAL REPORT (NOT PART OF THE MEDICAL RECORD)

Date of Occurrence/Event:______________________ Time:__________
Date Notified of Incident:______________________ Location:__________
Person Reporting Incident/title or relationship:______________________

Type of Occurrence: ☐ Patient ☐ Employee
Check all that apply: ☐ Delivery Problem ☐ Medication Error ☐ Adverse Drug Reaction ☐ Allergic Reaction
☐ Needle Stick ☐ Equipment Malfunction
Fall: ☐ Attended by agency employee ☐ Unattended ☐ Without Injury ☐ With Injury

Fall Risks Impacting Fall: check all that apply

History of falls	☐ Yes ☐ No	Incontinence/Urgency	☐ Yes ☐ No
Over 65	☐ Yes ☐ No	Impaired mobility	☐ Yes ☐ No
Multiple medications	☐ Yes ☐ No	Impaired transferring	☐ Yes ☐ No
Mental impairment	☐ Yes ☐ No	Environmental hazards	☐ Yes ☐ No

☐ Other (describe)______________________

Name ☐ Patient ☐ Employee:______________________
Address:______________________
Phone:______________________
Attending Physician:______________________ Notified: ☐ Yes ☐ No ☐ NA
If yes, to whom:______________________ Date:__________ Time:__________
Legal Counsel:(If any)______________________ Notified: ☐ Yes ☐ No ☐ NA

Describe the occurrence/incident:______________________

Treated at ER ☐ Yes ☐ No ☐ NA Facility______________________

Witness(es) to Occurrence: ☐ Yes ☐ No If yes, give name and phone number of witness(es):

______________________ __________
Employee Completing Report/Title Date

MANAGEMENT REVIEW

Corrective Action/Comments:______________________

☐ NO CORRECTIVE ACTION OR FOLLOW UP NEEDED

______________________ __________
Signature and Title Date

Follow-Up/Actions taken on recommendations (including dates):______________________

______________________ __________
Signature and Title Date