**PATIENT INCIDENT REPORT FORM**

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| **INDIVIDUAL FILING REPORT** |

**Full Name**: [FULL NAME] **Title/Role**: [TITLE/ROLE]

**Signature**: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_](https://esign.com/) **Date**: [DATE]

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| **PATIENT INVOLVED** |

**Full Name**: [PATIENT NAME] **Date of Birth**: [DATE]

**Address**: [ADDRESS] **Patient ID No.**: [PATIENT ID NO.]

**Sex**:  Male  Female  Other **Phone**: [PHONE] **E-Mail**: [EMAIL]

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| **INCIDENT DETAILS** |

**Date of Incident**: [DATE OF INCIDENT] **Time**: [TIME]  AM  PM

**Location**: [LOCATION]

**Incident Type**:  Accident  Injury  Illness  Self-Harm  Medication or Procedure Error

Behavior  Loss or Theft  Damage  Other: [OTHER]

**Describe the Incident**: [DESCRIBE THE INCIDENT]

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| **RESPONDING ACTIONS** |

**Describe the actions taken in response to the incident**: [DESCRIBE RESPONSE]

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| **INJURIES / DAMAGE** |

**Was anyone injured?**  Yes  No

**If yes, describe the injuries**: [INJURY DESCRIPTION]

**Was there any exposure to body fluids?**  Yes  No

**If yes, describe exposure and action taken**: [EXPOSURE DESCRIPTION AND RESPONSE]

**Was there any damage to equipment or property?**  Yes  No

**If yes, describe the damage**: [DAMAGE DESCRIPTION]

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| **WITNESSES** |

**Were there witnesses to the incident?**  Yes  No

**If yes, enter the witnesses’ names and contact info**:

1. **Full Name**: [NAME] **Phone**: [PHONE] **E-Mail**: [EMAIL]
2. **Full Name**: [NAME] **Phone**: [PHONE] **E-Mail**: [EMAIL]
3. **Full Name**: [NAME] **Phone**: [PHONE] **E-Mail**: [EMAIL]

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| **OFFICE USE ONLY** |

**Report received by**: [FULL NAME]

**Signature**: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_](https://esign.com/) **Date**: [DATE]

**Follow-up action taken**: [FOLLOW-UP ACTION TAKEN]