**PATIENT INCIDENT REPORT FORM**

|  |
| --- |
| **INDIVIDUAL FILING REPORT** |

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

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

|  |
| --- |
| **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]

|  |
| --- |
| **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]

|  |
| --- |
| **RESPONDING ACTIONS** |

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

|  |
| --- |
| **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]

|  |
| --- |
| **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]

|  |
| --- |
| **OFFICE USE ONLY** |

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

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

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