PATIENT INCIDENT REPORT FORM

INDIVIDUAL FILING REPORT

Full Name: ________________________________ **Title/Role**: ___________________________

Signature: _______________________________ **Date**: _______________

PATIENT INVOLVED

Full Name: ________________________________ **Date of Birth**: _______________

Address: ____ **Patient ID No.**: _______________

Sex: ☐ Male ☐ Female ☐ Other **Phone**: ______________ **E-Mail**: __________________

INCIDENT DETAILS

Date of Incident: _______________ **Time**: _________ ☐ AM ☐ PM

Location: ____

Incident Type: ☐ Accident ☐ Injury ☐ Illness ☐ Self-Harm ☐ Medication or Procedure Error ☐ Behavior ☐ Loss or Theft ☐ Damage ☐ Other: ___________________

Describe the Incident:

IMMEDIATE RESPONSE

Describe the actions taken in response to the incident:

INJURIES / DAMAGE

Was anyone injured? ☐ Yes ☐ No

If yes, describe the injuries:

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

If yes, describe exposure and action taken:

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

If yes, describe the damage:

WITNESSES

Were there witnesses to the incident? ☐ Yes ☐ No

If yes, enter the witnesses' names and contact info:

1. **Full Name**: ______________________ **Phone**: ______________ **E-Mail**: ___________________
2. **Full Name**: ______________________ **Phone**: ______________ **E-Mail**: ___________________
3. **Full Name**: ______________________ **Phone**: ______________ **E-Mail**: ___________________

OFFICE USE ONLY

Report received by: ______________________

Signature: ________________________________ **Date**: _______________

Follow-up action taken: