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:

RESPONDING ACTIONS

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: