INCIDENT REPORT - PATIENT/CLIENT

PATIENT/ CLIENT (Last name) (First name) (Middle initial) ❍ Male ❍ Female Age _____

Date of incident | Time of incident ❍ AM ❍ PM | Exact location of incident: ❍ Bedroom ❍ Hallway ❍ Bathroom ❍ Other, specify:

Date reported to agency | Person reporting incident (name/title/relationship)

Was patient/client alone? ❍ Yes ❍ No, If No, name/relationship and phone number of incident witness(es):

Patient/client diagnoses:

Medication(s) taken within 4 hours potentially related to incident? ❍ No ❍ Yes
If Yes, specify medication(s):

INCIDENT TYPE:

❑ Fall
❑ Property loss/damage:
❑ Jewelry ❑ Money ❑ Other_____
❑ Exposure to blood/body fluid
❑ Exposure to COVID-19
❑ Exposure to other infection
❑ Other_____

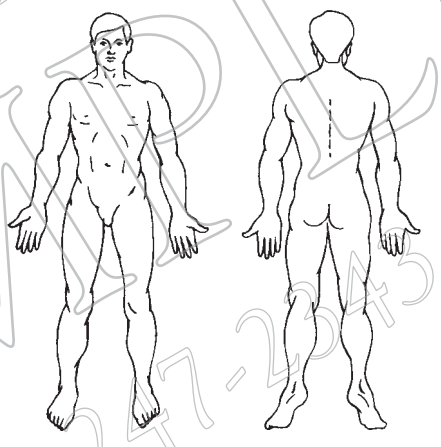
❑ **EQUIPMENT/MEDICAL DEVICE:**
Type:_____
Vendor:_____

❑ **MEDICATION/ADVERSE DRUG/BLOOD/IV**
Administered by: ❍ Staff ❍ Patient/Caregiver
❑ Wrong drug/product ❑ Wrong procedure/treatment
❑ Wrong time/delayed ❑ Adverse drug reaction
❑ Wrong dose ❑ Allergic reaction
❑ Wrong route ❑ Accidental needle stick
❑ Wrongly dispensed ❑ Omission
❑ Other_____

❑ **NO INJURY** **TYPE OF INJURY:** ❑ Laceration ❑ Hematoma ❑ Abrasion ❑ Burn ❑ Swelling ❑ Pain ❑ None apparent ❑ Other, specify:

Location of injury:

Indicate on diagram location of injury.



VITAL SIGNS
Temp._____
HR_____
Resp._____
BP_____
❍ Lying ❍ Sitting ❍ Standing

LEVEL OF CONSCIOUSNESS
_____
_____
_____
_____
_____

Describe exactly what happened; why it happened; what the causes were. Describe details of injury. If property or equipment damaged, describe damage.

Care manager notified? ❍ No ❍ Yes ❍ NA | Legal counsel notified? ❍ No ❍ Yes ❍ NA

Attending physician notified? ❍ No ❍ Yes ❍ NA
If Yes, Name: | Time of notification ❍ AM ❍ PM | Time responded ❍ AM ❍ PM

Name of family member/other notified | Relationship | Time of notification ❍ AM ❍ PM | Time responded ❍ AM ❍ PM

Was person involved seen by a physician? ❍ No ❍ Yes If Yes, physician's name | Where | Date | Time ❍ AM ❍ PM

Was first aid administered? ❍ No ❍ Yes If Yes, type of care provided and by whom | Where | Date | Time ❍ AM ❍ PM

Was person involved taken to ER? ❍ No ❍ Yes
If Yes, hospitalized? ❍ No ❍ Yes | Transported by whom | Facility | Date | Time

SIGNATURE/TITLE/DATE | **SIGNATURE/TITLE/DATE**

Person Preparing Report | Reviewed by