PATIENT INCIDENT REPORT

Date of Report: _____, 20___

Patient Involved

Name: _____ Date of Birth: _____

Medical Record Number: _____ Admission Date: _____

Incident Details

Date: _____ Time: _____ ☐ AM ☐ PM

Location: _____

Type of Incident: (Check all that apply)

☐ Patient Fall ☐ Medication Error

☐ Treatment Complication ☐ Equipment Malfunction

☐ Hospital-Acquired Infection ☐ Other: _____

Describe the incident:

_____
_____
_____
_____
_____
_____

Actions Taken

Was immediate medical intervention required? ☐ Yes ☐ No

Describe the actions taken:

_____
_____
_____
_____
_____

Was the patient's attending physician notified?
☐ Yes ☐ No

Name of attending physician:
_____

Witness(es)

Were there any witnesses to the incident? ☐ Yes ☐ No

Witness Name: _____

Contact Information: _____

Witness Name: _____

Contact Information: _____

Supporting Document

Are supporting documents attached?
☐ Yes ☐ No

Describe the supporting documents:
_____
_____
_____

Reporting Person

Name: _____ Role: _____

Signature: _____ Date: _____