

REPORTABLE OCCURRENCE

Please Print or Type

Print or Use Plastic Plate if available

Name of:

- Patient
 Visitor
 Employee

INSURANCE Medicare Medicaid Other None Not Applicable

HOME ADDRESS	MEDICAL RECORD # OR SOCIAL SECURITY #	AGE	SEX
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PRINCIPAL DIAGNOSIS	INCIDENT DATE	TIME <input type="checkbox"/> AM <input type="checkbox"/> PM
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ATTENDING PHYSICIAN	LOCATION CODE, NURSING UNIT
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NATURE OF INCIDENT <input type="checkbox"/> AMA/Elopement <input type="checkbox"/> Blood Products/Transfusion <input type="checkbox"/> Combative Patient/Visitor <input type="checkbox"/> Drug Reaction <input type="checkbox"/> Medical Device <input type="checkbox"/> Equipment Type: _____ UK #: _____ Serial #: _____ <input type="checkbox"/> Other Medical Device: _____	<input type="checkbox"/> Exposure: <input type="checkbox"/> Body Fluids <input type="checkbox"/> Infectious Disease <input type="checkbox"/> Chemical (describe): _____ <input type="checkbox"/> Fall <input type="checkbox"/> Labeling <input type="checkbox"/> Needle Stick	<input type="checkbox"/> Patient Identification <input type="checkbox"/> Property <input type="checkbox"/> Damaged <input type="checkbox"/> Lost <input type="checkbox"/> Stolen <input type="checkbox"/> Transcription <input type="checkbox"/> Treatment <input type="checkbox"/> Other _____	<input type="checkbox"/> Medication (check all that apply) <input type="checkbox"/> Oral <input type="checkbox"/> IM <input type="checkbox"/> Type <input type="checkbox"/> IV <input type="checkbox"/> Other <input type="checkbox"/> Dosage <input type="checkbox"/> Patient ID. <input type="checkbox"/> Time <input type="checkbox"/> Unordered <input type="checkbox"/> Route <input type="checkbox"/> Duplicated <input type="checkbox"/> Infusion Rate <input type="checkbox"/> Omitted <input type="checkbox"/> Solution	<input type="checkbox"/> Orders <input type="checkbox"/> Correctness <input type="checkbox"/> Completeness <input type="checkbox"/> Legibility <input type="checkbox"/> Duplicated
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OUTCOME (Check all that apply)			
<input type="checkbox"/> No apparent injury	<input type="checkbox"/> Injury (medical attention recommended) <input type="checkbox"/> Asphyxia, strangulation	<input type="checkbox"/> Fracture, dislocation	<input type="checkbox"/> Other (describe): _____
<input type="checkbox"/> Minor Injury (no medical attention required)	<input type="checkbox"/> Burn, scald <input type="checkbox"/> Concussion <input type="checkbox"/> Contusion, cut, laceration	<input type="checkbox"/> Inhalation <input type="checkbox"/> Puncture <input type="checkbox"/> Sprain, strain	<input type="checkbox"/> Not Applicable

PATIENT DISPOSITION AT TIME OF INCIDENT <input type="checkbox"/> Alone <input type="checkbox"/> Family/Visitor Present <input type="checkbox"/> Staff Present <input type="checkbox"/> Not Applicable
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BRIEFLY EXPLAIN THE FACTS AT YOU KNOW THEM (attach additional sheets if necessary)

NAME AND ADDRESS OF WITNESSES (Hospital Staff and Others)
_____ Phone _____
_____ Phone _____
_____ Phone _____

IMMEDIATE CORRECTIVE ACTION TAKEN
<input type="checkbox"/> Not Applicable Referred to: <input type="checkbox"/> Emergency Room <input type="checkbox"/> Clinic <input type="checkbox"/> Personal Physician
Notified: <input type="checkbox"/> Physician (Name): _____ <input type="checkbox"/> Supervisor <input type="checkbox"/> Security <input type="checkbox"/> Equipment Svcs.
<input type="checkbox"/> Other (describe): _____

DID INJURED PERSON RECEIVE MEDICAL TREATMENT <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused <input type="checkbox"/> Not Applicable

PHYSICIAN FINDINGS AND PRESCRIBED TREATMENTS

NAME AND TITLE OF PERSON REPORTING (Print)	DATE OF REPORT	TIME OF REPORT
SUPERVISOR'S SIGNATURE	DEPARTMENT HEAD SIGNATURE	WORKER'S COMP (SF-1) FORM COMPLETED <input type="checkbox"/> YES <input type="checkbox"/> NO

INSTRUCTIONS:

1. Complete all sections of this form. If a section is not applicable, so indicate.
 2. Upon completion of form, submit to supervisor during shift in which occurrence was discovered.
 3. Supervisor or department head must deliver completed and signed form to Hospital Risk Management within 24 hours of occurrence.
- NOTE: If employee injury, Worker's Compensation (SF-1) form must also be completed.

SM/DA Applicable