MISCELLANEOUS INCIDENT REPORT

The following information is confidential. This report may not be photocopied and *is not* part of the medical record.

INCIDENT DATE & TIME:_____ REPORT DATE:_____

PERSON INVOLVED: ___Patient ___Visitor ___Employee ___Volunteer ___Other:_____ **___N/A**

DEPARTMENT: ___Nursing ___Lab ___ X-ray ___Dietary ___Housekeeping ___Laundry ___Maintenance
___Pharmacy ___Respiratory Therapy ___Physical Therapy ___Medical Records ___Business Office
___Admitting ___Personnel ___Administration ___Other:_____

NAME:_____ AGE:_____ SEX:_____ LOCATION:_____

DIAGNOSIS (if applicable):_____ADM #:_____

ADDRESS (if applicable):_____

INCIDENT TYPE: ___Assault - Was a weapon involved? YES NO If yes, what type? _____
___Equipment ___Diagnostic test at wrong time/sequence ___Diagnostic test omitted ___Fire
___Consent ___Lost /damaged property ___Lost specimen ___Missing instrument(s)
___Missing needle(s) ___Missing sponge ___Treatment omitted ___Patient left ___Smoking
___Wrong diet ___Wrong treatment ___Wrong diagnostic test ___Theft
___Other:_____

BRIEF DESCRIPTION OF INCIDENT:_____

_____

_____

PHYSICIAN NOTIFIED?: *Yes No* **DR.:_____DATE&TIME:_____ INITIALS:_____**

WITNESSES: Name:_____ Comments:_____
Name:_____ Comments:_____
Name:_____ Comments:_____

(Continue with comments on back of form if necessary.)

EQUIPMENT MANUFACTURER (if applicable):_____

Serial #, Lot #, Bed #, Tag #, etc.:_____

(Remove involved equipment from use immediately and send to Maintenance for check and repair.)

INJURY INVOLVED: ***NONE*** **or Describe:_____**

_____

SEEN BY PHYSICIAN?: *Yes No* **DR.:_____ Where?:** ___*Emergency Room* ___*Office*

(Please attach copy of ER Rocord if applicable)

TREATMENT: ___NONE ___MINOR (heat, cold, dressings) ___SIGNIFICANT (X-ray, sutures, tests)
___MAJOR (treatment, surgery)
Describe:_____
_____

REPORTED BY:_____SHIFT SUPERVISOR:_____

Revised: 11/04