

## Health Center Incident Report Form

### Section 1: Incident Information

Date of Incident: \_\_\_\_\_

Time of Incident: \_\_\_\_\_

Location of Incident:  Exam Room  Waiting Area  Restroom  Hallway  Other:

\_\_\_\_\_

Type of Incident:  Patient Injury  Staff Injury  Property Damage  Medication Error

Security Incident  Other: \_\_\_\_\_

### Section 2: Reporting Individual Information

Name of Reporter: \_\_\_\_\_

Job Title/Role: \_\_\_\_\_

Contact Information:

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

### Section 3: Involved Individuals

#### Patient Information

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Medical Record Number: \_\_\_\_\_

Contact Information:

Phone: \_\_\_\_\_

Address: \_\_\_\_\_

#### Staff/Volunteer Information

Staff Name: \_\_\_\_\_

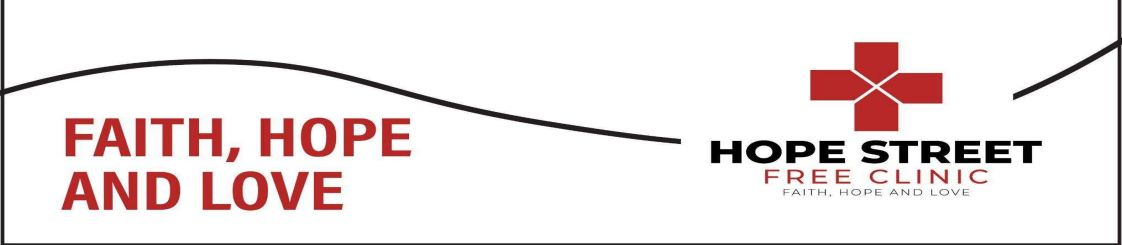
Job Title/Role: \_\_\_\_\_

Contact Information:

- Phone: \_\_\_\_\_

- Email: \_\_\_\_\_

### Section 4: Description of Incident



Detailed Description of Incident:

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**Actions Taken Immediately Following the Incident:**

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**Section 5: Witness Information**

Name(s) of Witness(es): \_\_\_\_\_

Job Title/Role: \_\_\_\_\_

Contact Information:

- Phone: \_\_\_\_\_

- Email: \_\_\_\_\_

**Witness Statement:**

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**Section 6: Follow-Up Actions**

Follow-Up Actions Taken:

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Additional Actions Needed:

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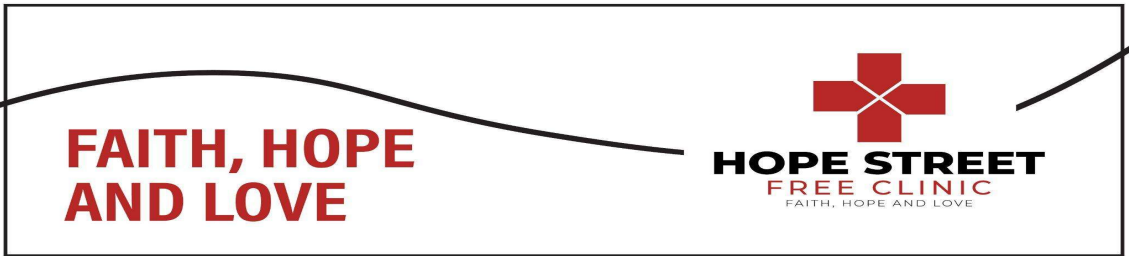
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**Section 7: Attachments**

Attach Relevant Documents:

Photographs  Medical Records  Witness Statements  Other:

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**Section 8: Report Review and Action**

Reviewed By: \_\_\_\_\_  
Job Title/Role: \_\_\_\_\_  
Date of Review: \_\_\_\_\_

**Action Plan Developed:**

\_\_\_\_\_  
\_\_\_\_\_

Follow-Up Date: \_\_\_\_\_  
Resolved:  Yes  No

**Section 9: Signature**

Reporter's Signature: \_\_\_\_\_  
Date: \_\_\_\_\_

**Instructions:**

- Complete this form as soon as possible after the incident.
- Submit the form to the Risk Manager or designated person.
- Retain a copy for your records.