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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 Information

- **Staff Name:** _____
- **Job Title/Role:** _____
- **Contact Information:**
  - Phone: _____ Email: _____

Section 4: Description of Incident

- **Detailed Description of Incident:**

- **Actions Taken Immediately Following the Incident:**

Section 5: Witness Information

- **Name(s) of Witness(es):** _____
- **Job Title/Role:** _____
- **Contact Information:**
  - Phone: _____
  - Email: _____
- **Witness Statement:**

Section 6: Follow-Up Actions

- **Follow-Up Actions Taken:**

- **Additional Actions Needed:**

Section 7: Attachments

- **Attach Relevant Documents:**
  - ☐ Photographs
  - ☐ Medical Records
  - ☐ Witness Statements
  - ☐ Other: _____

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