MEDICAL INCIDENT REPORT FORM

Report ID: _____ Date Form Completed: _____ Time: _____

TEMPORAL DOCUMENTATION

Date of Incident: //____ (MM/DD/YYYY)
Time of Incident: _____ ☐ AM ☐ PM ☐ 24-hour format
Duration of Incident: From _____ to _____ (if applicable)

☐ Exact time ☐ Approximate time
If approximate, explain why: _____

LOCATION OF INCIDENT

Physical Address: _____
Department/Ward: _____ Room/Unit Number: _____
Specific Location: _____

Environmental Conditions at Time of Incident:
☐ Adequate lighting ☐ Poor lighting ☐ Wet floor ☐ Equipment obstructing path
☐ Other: _____

Accessibility Features Present:
☐ Grab bars ☐ Call button ☐ Bed rails ☐ Wheelchair accessible
☐ Other: _____

INDIVIDUAL DOCUMENTATION

Patient Information:

Full Legal Name: _____
Medical Record Number: _____ Account Number: _____

Date of Birth: //_____ Age: _____ Gender: ☐ M ☐ F ☐ Other
Patient Status: ☐ Inpatient ☐ Outpatient ☐ Emergency Department ☐ Visitor

Other Individuals Involved:

Name: _____ Role: ☐ Staff ☐ Visitor ☐ Contractor
Name: _____ Role: ☐ Staff ☐ Visitor ☐ Contractor

PATIENT CLINICAL DETAILS

Relevant Medical History: _____

Current Medications (if relevant to incident): _____

Physical Limitations: ☐ Mobility impaired ☐ Vision impaired ☐ Hearing impaired
☐ Other: _____

Cognitive Status at Time of Incident:
☐ Alert and oriented ☐ Confused ☐ Sedated ☐ Unconscious
☐ Other: _____

Communication Barriers: ☐ Language barrier ☐ Interpreter needed ☐ None
Specify: _____

WITNESS INFORMATION

Witness 1:
Name: _____ Title/Position: _____
Phone: _____ Relationship to Incident: _____
Location During Incident: _____
Statement: _____

Signature: _____ Date: _____

Witness 2:
Name: _____ Title/Position: _____

Phone: _____ Relationship to Incident: _____
Statement: _____

Signature: _____ Date: _____

INCIDENT CLASSIFICATION

Primary Category:
☐ Medication error ☐ Patient fall ☐ Equipment failure ☐ Surgical incident
☐ Healthcare-associated infection ☐ Security incident ☐ Violence/aggression
☐ Patient self-injury ☐ Other: _____

Severity Level:
☐ Death ☐ Severe harm ☐ Moderate harm ☐ Mild harm ☐ No harm ☐ Near miss

Regulatory Category:
☐ Sentinel event ☐ OSHA reportable ☐ Fraud/Waste/Abuse ☐ Not applicable

DETAILED INCIDENT DESCRIPTION

What was happening before the incident?

Describe the incident in chronological order:

Environmental factors that may have contributed:

Communication issues (if any):

System factors that may have contributed:
☐ Staffing levels ☐ Workload ☐ Policy not followed ☐ Equipment malfunction
☐ Training inadequate ☐ Other: _____

INJURY AND MEDICAL ASSESSMENT

Was an injury sustained? ☐ Yes ☐ No

If yes, complete the following:

Location of injury on body: _____
Description of injury: _____
Size/Appearance: _____
Mechanism of injury: _____

Treatment Required:
☐ No treatment ☐ First aid ☐ Physician evaluation ☐ Emergency department
☐ Surgery ☐ Hospitalization ☐ Other: _____

Care Provider: _____ Time Care Provided: _____
Location Care Provided: ☐ On-site ☐ Emergency Department ☐ Other facility

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VISUAL DOCUMENTATION

Photos taken? ☐ Yes ☐ No
If yes, list photo descriptions:
☐ Patient identification ☐ Scene overview ☐ Injury close-up ☐ Equipment
☐ Environmental factors ☐ Other: _____

Photographer: _____ Time photos taken: _____

IMMEDIATE ACTIONS TAKEN

Emergency interventions performed:

Notifications made: *(Include time of each notification)*
☐ Physician: _____ Time: _____
☐ Supervisor: _____ Time: _____
☐ Risk Management: _____ Time: _____

☐ Family: _____ Time: _____
☐ Other: _____ Time: _____

Safety measures implemented:

_____

Protocols followed:

_____

_____

OUTCOMES AND RESOLUTION

Patient status at time of report:
Physical condition: _____
Mental/cognitive status: _____

Follow-up requirements:
☐ Ongoing monitoring ☐ Specialist referral ☐ Additional testing
☐ Other: _____

Recommended system changes:

_____

_____

Preventive measures to prevent recurrence:

_____

_____

_____

REPORTER INFORMATION

Name: _____ Title: _____
Department: _____ Phone: _____
Email: _____

Relationship to incident:
☐ Direct witness ☐ First responder ☐ Supervisor ☐ Other: _____

Signature: _____ Date: _____ Time: _____

_____

ADMINISTRATIVE USE ONLY

Report reviewed by: _____ Date: _____
Risk Management notified: ☐ Yes ☐ No Date: _____
External reporting required: ☐ Yes ☐ No Agency: _____
Follow-up actions assigned: _____

Case Status: ☐ Open ☐ Under investigation ☐ Closed
Final disposition: _____

This form is confidential and should be handled according to organizational policies regarding incident reporting and patient privacy.