

Incident Report

I. To be completed by Supervisor

No:

Name of Person Involved			Position	Department	Specialty
Age	Gender	ID #/Patient #	Date of Incident	Time	Location

Status

<input type="checkbox"/> Staff	<input type="checkbox"/> Resident Staff	<input type="checkbox"/> Casual Worker	<input type="checkbox"/> Inpatient	<input type="checkbox"/> Other (Specify)
<input type="checkbox"/> Faculty/Medical Staff	<input type="checkbox"/> Student	<input type="checkbox"/> Visitor	<input type="checkbox"/> Outpatient/ED Patient

Category of Incident

<input type="checkbox"/> Chemical/Radioactive Exposure	<input type="checkbox"/> Fire	<input type="checkbox"/> Breach of Safety	<input type="checkbox"/> Treatment Problem/Delay/Error
<input type="checkbox"/> Biological Exposure	<input type="checkbox"/> Flood	<input type="checkbox"/> Breach of Security	<input type="checkbox"/> Patient Fall
<input type="checkbox"/> Laceration	<input type="checkbox"/> Spill	<input type="checkbox"/> Breach of Policies	<input type="checkbox"/> Documentation Error
<input type="checkbox"/> Back Injury	<input type="checkbox"/> Property Damage	<input type="checkbox"/> Breach in Scope of Practice	<input type="checkbox"/> Misidentification
<input type="checkbox"/> Slip/Trip/Fall	<input type="checkbox"/> Equipment Failure	<input type="checkbox"/> Breach of Confidentiality	<input type="checkbox"/> Faulty Equipment/Product
<input type="checkbox"/> Other Bodily Injury	<input type="checkbox"/> Burn	<input type="checkbox"/> Physical/Verbal Abuse	<input type="checkbox"/> Other (Specify):

<input type="checkbox"/> Needle prick (Please complete below)			
<u>Injury Occurred</u>		<u>Type of Device</u>	
<input type="checkbox"/> During use on patient (single step)	<input type="checkbox"/> After use before disposal	<input type="checkbox"/> Suture Needle	Device With Safety Feature
<input type="checkbox"/> Use in multi-step procedure	<input type="checkbox"/> Putting into sharp container	<input type="checkbox"/> IV Catheter	<input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/> Assisting in procedure (not main user)	<input type="checkbox"/> Left in inappropriate place	<input type="checkbox"/> Blade	Disposable Syringe:
<input type="checkbox"/> Other (Specify):		<input type="checkbox"/> Other (Specify):	<input type="checkbox"/> Blood Withdrawal
<input type="checkbox"/> Patient Number:	Device Brand:	<input type="checkbox"/> Device Size:	<input type="checkbox"/> Injection

Complete description of the incident and actions taken* (any objects, tools, chemicals, potential source of infection involved, etc.)

Corrective measures to prevent similar incidents*

Completed by	Signature	Statement of involved person or person completing the report	
Witnessed by	Signature		
Department Head/Supervisor	Signature	Name	Date

II. In Case of INJURY to be completed by Physician

Nature of injury and body part(s) affected:

Extent of Injury	Medical Intervention
<input type="checkbox"/> None (<i>No injury</i>)	Was the individual involved suffering from pre-existing disease or disability before the incident?
<input type="checkbox"/> Minor (<i>Cleaning of wound or topical medication</i>)	<input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/> Moderate (<i>Suturing or splinting</i>)	<input type="checkbox"/> Diagnostic Procedure:
<input type="checkbox"/> Major (<i>Surgery, neurological or internal injury</i>)	<input type="checkbox"/> Treatment (Medical/Surgical):
<input type="checkbox"/> Catastrophic (Disability or death)	<input type="checkbox"/> No Treatment

Will the incident result in a permanent defect or disability? No Yes

Was a sick leave given to the injured? No Yes days

Additional comments by Physician*

Physician Name: **Physician Signature:** **Status:** **Date:**

I authorize the physician to release this report or any part of its content for administrative purposes

لقد تم شرح محتويات هذا التقرير وإني أخول الطبيب إبراز هذا التقرير أو أي جزء منه إذا اقتضت الحاجات الإدارية

Signature of Injured:

Distribution: If patient-related incident, send to Accreditation & Risk Manager. If non patient-related incident, send to Risk Manager at EHSRM

*Use back of form or additional sheet if more space is needed