



Reporting Service

PERSON INVOLVED IN INCIDENT	<input type="checkbox"/> INPATIENT <input type="checkbox"/> OUTPATIENT <input type="checkbox"/> VISITOR <input type="checkbox"/> STAFF <input type="checkbox"/> OTHER _____						
	Name		Address		City/State/Zip	Age	Sex
	Social Security No.		Military Status		Duty Station (Active Duty)		
	Home Telephone No.		Work Telephone No.		CONDITION OF PERSON BEFORE INCIDENT <input type="checkbox"/> N/A <input type="checkbox"/> Alert <input type="checkbox"/> Disoriented <input type="checkbox"/> Sedated <input type="checkbox"/> Senile <input type="checkbox"/> Other		

IN-PATIENT ONLY	Date Admitted	Register No.	Current Diagnosis							
	BED POSITION AT TIME OF INCIDENT		BED RAILS		Sedation (Medicated Past 6 Hrs of Incident)					
	<input type="checkbox"/> High	<input type="checkbox"/> Low	<input type="checkbox"/> Not Adjustable	<input type="checkbox"/> N/A	<input type="checkbox"/> Up	<input type="checkbox"/> Down	<input type="checkbox"/> N/A	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Type _____

TYPE OF INCIDENT	<input type="checkbox"/> Admission	<input type="checkbox"/> Cardio-Pulmonary Arrest	<input type="checkbox"/> Medication SQ/IM	<input type="checkbox"/> Suicide
	<input type="checkbox"/> Anesthesia	<input type="checkbox"/> Equip. Failure	<input type="checkbox"/> Medication IV	<input type="checkbox"/> Surgical
	<input type="checkbox"/> Bill/Payment	<input type="checkbox"/> Fall	<input type="checkbox"/> Procedure	<input type="checkbox"/> Treatment
	<input type="checkbox"/> Blood Incident Transfusion	<input type="checkbox"/> Fire	<input type="checkbox"/> Personal Effects Valuable Loss	<input type="checkbox"/> Report Type If not listed above
	<input type="checkbox"/> Burn	<input type="checkbox"/> Medication PO	<input type="checkbox"/> Pt. Complaint/Dissatisfaction	
	<input type="checkbox"/> Equipment/Surgical Supplies Loss			

Date	Time	Branch/Section/Clinic/Ward Where Incident Occurred	Exact Location of Incident
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INCIDENT DESCRIPTION	Describe Incident in Chronological Order		

Person Preparing Report	Name of Person Preparing Report (PRINT)		Telephone No.	Date	Time
	Signature of Person Preparing Report		GRADE/RATE AND TITLE		

MEDICAL OFFICER EXAMINING PATIENT	Nature of Injury - Findings - Treatment		Extent of Injury		
			<input type="checkbox"/> one	<input type="checkbox"/> or	
			<input type="checkbox"/> ere	<input type="checkbox"/> D	<input type="checkbox"/> h
Name of Examining Physician (PRINT)		Signature/GRADE	Work Telephone No.	Date	Time
WITNESS OBSERVING INCIDENT	Name		Telephone No.		
	Home Address		City/State/Zip		
	Name		Telephone No.		
	Home Address		City/State/Zip		
QUALITY ASSURANCE/ RISK MANAGEMENT COORDINATOR OR DESIGNATED INDIVIDUAL INVESTIGATING AND EVALUATING THIS INCIDENT	Incident Report Routing Comments*				
Problem Identified:					
Action Taken:					
Name of QA/RM Coordinator or Investigator (PRINT)		Signature/GRADE	Date		

\* Notify and forward Incident Report form to Quality Assurance/Risk Management Coordinator, or follow routing procedure determined by Commanding Officer/Officer in Charge