



Embrace Excellence

Patient/Visitor Incident Report

Person Involved

Name:	<i>Patient</i> _____ <i>Visitor</i> _____
Location of the Incident:	
Date of Incident:	
<i>Explain in detail how the incident occurred and action taken – include dates, persons involved and location in description:</i>	

Report of examining Physician's physical findings and treatment:

Was individual referred to a physician? _____
If yes, Physician's name: _____
Did individual refuse care? _____
If yes, why?
Remarks/Recommendations/Actions Taken:
Did testing take place? _____ Date: _____
If yes, please add details to remarks above.

Witness to Incident: (Please indicate if patient, visitor or associate)

Name:	Name:
Address:	Address:
Phone:	Phone:

<i>Incident Reported By:</i>	<i>Date:</i>
<i>Patient/Visitor Signed:</i>	<i>Date:</i>
<i>Report Prepared By:</i>	<i>Date:</i>

Incident Reviewed by Executive Board: _____ Date _____
Incident Reviewed by Quality Assurance Committee – Quality Assurance Committee Actions/Recommendations: _____ _____ _____ _____
Date: _____

Follow-up Required: _____ _____ _____ _____

THIS REPORT SHOULD BE COMPLETED IMMEDIATELY AND RETURNED TO

Human Resources