WellsBrooke
CERTIFIED HOME HEALTH CARE

Incident Report

Instructions: *Complete and return this form to Administrator within 24 hours of the incident. Use additional sheet if needed.*

Person Involved in the Incident:_____

Mark all that apply: ☐ Patient ☐ Agency Staff ☐ Other (specify): _____

DOB: _____ Male_____ Female_____

Date of Incident: _____ Time: _____ AM/PM

Location of Incident: _____

Type of Incident:

☐ Medication Issues:
- ☐ Error
- ☐ Adverse side effects
- ☐ Other: _____

☐ Damaged Property

☐ Suspected Theft

☐ Cardiac Arrest

☐ Needlestick

☐ Fall: Witnessed / Not Witnessed (circle one)
- ☐ No injury noted
- ☐ With injury noted: _____

☐ Injury/accident

☐ Abuse: Specify:_____

☐ Medical Device Failure: Specify Type/Lot #:_____

☐ Biohazard Exposure

☐ Other:_____

Details of Incident (who/what/where/how/why, include sequence of events):

_____

_____

_____

_____

Actions Taken by Staff Members: _____

_____

_____

Medical Follow-Up: Was Medical Attention Sought: ☐ Yes ☐ No

Treatment Refused: ☐ Yes ☐ No Date of First Treatment: _____

Treating Physician: _____ Phone Number: _____

Supervisor Notified: ☐ No ☐ Yes Date:_____ Time: _____

Name of Supervisor: _____

Supervisor Comments: _____

_____

_____

Supervisor Signature/Title: _____ Date: _____

Worker Compensation first report sent: ☐ Yes ☐ No Date: _____ OSHA 300 Log #: _____

Permission for blood to be tested for HIV (known to cause AIDS), HBV and HCV given: ☐ Yes ☐ No

Corrective Action Taken/Follow-Up (Actions that have been or will be taken to prevent reoccurrence):

_____

_____

Individual Completing Report:_____ **Date:**_____