NORTHEAST OHIO NEIGHBORHOOD HEALTH SERVICES, INC.

PATIENT/VISITOR INCIDENT REPORT FORM

PART 1 – PATIENT/VISITOR IDENTIFICATION INFORMATION

Name: _____ Department: _____
Site Location: _____
Home Address: _____ Home Phone: (____) _____
Cell Phone: (____) _____
Pager No.: (____) _____
City State and Zip Code: _____
Sex: _____ Age: _____ Date of Birth: _____
Parent/Legal Guardian (if minor or otherwise designated): _____

PART 2 – INCIDENT ANALYSIS INFORMATION

Date of Incident: _____ Time of Incident: _____AM PM
Incident Location: _____
If off premises, please complete the following information:
Name of Organization: _____ Phone Number: (____) _____
Address: _____ City, State and Zip Code: _____

PART 3 – INCIDENT DESCRIPTION

Fully describe incident: _____
(PLEASE USE ADDITIONAL PAPER IF NECESSARY)

What factors led to the incident occurring? _____

Revised: 11/05
Revised: 07/06

PART 4 – WITNESS DESCRIPTION

Fully describe incident: _____
(PLEASE USE ADDITIONAL PAPER IF NECESSARY)

_____
_____
_____
_____

Signature of Witness_____
Signature of Witness_____
Signature of Witness_____

PART 5 – SUPERVISOR'S/CENTER DIRECTOR'S STATEMENT

Fully describe incident: _____
(PLEASE USE ADDITIONAL PAPER IF NECESSARY)

_____
_____
_____
_____
_____
_____

PART 6 – CORRECTIVE ACTION PLAN

Is there a corrective action plan required? _____ YES _____NO (Please check one)
Specific details of corrective action plan_____

_____
_____
_____
_____

Person(s) responsible for implementing and monitoring the above plan _____
Expected date of completion _____

PART 7 – SIGNATURE SECTION

PATIENT/VISITOR'S SIGNATURE_____ DATE _____

SUPERVISOR'S SIGNATURE _____ DATE _____
TITLE _____

CENTER DIRECTOR'S SIGNATURE _____ DATE _____
TITLE _____

REVIEWED BY_____ DATE _____
TITLE _____

NOTE 1: THIS FORM MUST BE COMPLETED AND FORWARDED TO THE CORPORATE SAFETY OFFICER WITHIN 48 HOURS OF THE INCIDENT

Revised: 11/05
Revised: 07/06

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PATIENT/VISITOR INCIDENT REPORT FORM INSTRUCTIONS

I. COMPLETION OF THIS REPORT

Parts 1, 2, and 3 must be completed by the PATIENT/VISITOR
Part 4 must be completed by a WITNESS
Part 5 and 6 must be completed by the SUPERVISOR
Part 7 must be completed by the PATIENT/VISITOR, SUPERVISOR, CENTER DIRECTOR AND SENIOR ADMINSTRATION

II. ADMINISTRATIVE ROUTING OF THIS REPORT

THE ORIGINAL COPY – CORPORATE SAFETY OFFICER
COPY 1 – SUPERVISOR
COPY 2 – CENTER DIRECTOR
COPY 3 – SENIOR ADMINISTRATION

Revised: 11/05