

**INCIDENT REPORT**

**Reportable incident:** (Submit within 72 hours of reportable incident.) Check appropriate box below.

- Absence without leave for one or more nights.
- Adverse reaction to a drug, medication error and/or treatment.
- Bodily injury requiring medical intervention.

<b>1. Facility Name</b>				
<b>2. Resident Name</b>	<b>3. Sex</b>	<b>4. Birthdate(mm/dd/yyyy)</b>	<b>5. Acuity Level at time of incident</b> <input type="checkbox"/> SNF <input type="checkbox"/> ICF <input type="checkbox"/> ICF/MR <input type="checkbox"/> Other	
<b>6. Diagnosis(es)</b>				
<b>7. Date &amp; Time of incident</b>		<b>8. Place of incident (e.g., hallway, bedroom, dining area, etc.)</b>		

(Note: If more space is needed, continue at the back of this form.)

**8. Description of incident:**

**9. Description of the kind & extent of medical intervention:** (Include/attach results of diagnostic tests; e.g., xrays, M.D. assessment, etc.)

**10. Corrective action(s):**

**11. Reported to other agency(ies); e.g., APS, DOH, MID:** Yes  \_\_\_\_\_ No   
Name(s)

**12. Name & Title of reporter:** \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**13. If NO reportable incidents have occurred in the facility from Jan.- June or July - Dec., pls. complete below and submit by the 15<sup>th</sup> of the month following the end of the reporting period.**

**NO REPORTABLE INCIDENT:**  Jan. – June, Year \_\_\_\_\_  July – Dec., Year \_\_\_\_\_

**Name & Title of reporter:** \_\_\_\_\_ **Facility Name:** \_\_\_\_\_

\_\_\_\_\_  
Signature **Date:** \_\_\_\_\_