Milford Regional Physician Group
The Benchmark for Quality Care

Milford Regional Physician Group
Incident/Occurrence Report

Patient Name:_____ Patient DOB:_____

Patient Address:_____

Incident/occurrence occurred on:

Date:_____ Time:_____ Site Name:_____

Site Address:_____

IMMEDIATELY notify Risk Manager or Practice Manager of any of the following incidents/occurrences. Indicate the type:

[ ] Fire
[ ] Death in the course of ambulatory surgery
[ ] Rape (by patient or staff)
[ ] Suicide

Identify the type(s) of incident/occurrence & complete the corresponding section(s).

[ ] 1. Medication/IV/Injection administration error
[ ] 2. Adverse drug reaction
[ ] 3. Fall
[ ] 4. Injury
[ ] 5. Lost/damaged personal property
[ ] 6. Healthcare provider behavior
[ ] 7. Damage to facility property
[ ] 8. Equipment related problem
[ ] 9. Other (describe in detail section)

1. MEDICATION/IV/INJECTION/IMMUNIZATION ADMINISTRATION ERROR

Medication/vaccine:_____

[ ] Contraindication/allergy
[ ] Dispensing error
[ ] Extra dose(s) #_____
[ ] Incorrectly administered
[ ] Medication mislabeled
[ ] Drug closet keys missing/ removed from building
[ ] Noncompliance
[ ] Preparation error
[ ] Omitted dose(s) #_____
[ ] Order not transcribed
[ ] Order transcribed incorrectly
[ ] Wrong drug
[ ] Wrong dose
[ ] Wrong patient
[ ] Wrong route
[ ] Wrong time
[ ] Other

2. ADVERSE DRUG REACTION (anything not usually expected as a result of the medication administered).

Drug name/dose/route:_____

[ ] Whole body
[ ] Cardiovascular
[ ] Central Nervous System
[ ] Ears, eyes, nose, throat
[ ] Gastrointestinal
[ ] Hematologic
[ ] Hepatic
[ ] Metabolic
[ ] Musculoskeletal
[ ] Psychiatric
[ ] Renal
[ ] Respiratory
[ ] Skin/dermatologic
[ ] Other

3. FALL (complete this section and complete injury section)

[ ] Assisted to floor
[ ] During transport
[ ] Found on floor
[ ] From exam table
[ ] From chair
[ ] From elevated level
[ ] In bathroom
[ ] While walking
[ ] While standing
[ ] Other

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(see reverse side)

4. INJURY (complete all sections) (Use "Employee Injury Report" for employee injuries)

Type of injury (note location next to any type selected):

[ ] Abrasions [ ] Contusions [ ] Laceration [ ] Unable to determine
[ ] Bruises [ ] Fracture [ ] None [ ] Other

Treatment required:

[ ] Death [ ] Hospitalization required [ ] No injury
[ ] Exam/treatment refused [ ] Medical treatment given [ ] Other

[ ] Examined by: (fill in name)_____
Attending MD notified: [ ] YES [ ] NO Time:_____ By:_____
Family Notified: [ ] YES [ ] NO Time:_____ By:_____

5. LOST/DAMAGED PROPERTY

[ ] Clothing [ ] Dentures [ ] Hearing aid(s) [ ] Money [ ] Other
[ ] Contact lens [ ] Glasses [ ] Jewelry [ ] Vehicle

6. HEALTH CARE PROVIDER BEHAVIOR

[ ] Abusive or disruptive behavior [ ] Offensive comments/remarks [ ] Throwing of objects
[ ] Cursing [ ] Refusal to care for patient [ ] Yelling
[ ] Failure to comply with Tri-County Medical policies & procedures [ ] Sexual advances/harassment [ ] Other

7. DAMAGE TO FACILITY PROPERTY

[ ] Collision [ ] Explosion [ ] Natural disaster [ ] Water/plumbing
[ ] Electrical [ ] Fire/smoke [ ] Theft [ ] Other

8. EQUIPMENT RELATED PROBLEM

[ ] Electrical shock [ ] Equipment/device failure [ ] Malfunction during use
[ ] Equipment unavailable [ ] Improper use [ ] Other

9. **Describe in detail (if additional space is needed, please use blank paper & attach to this form). Include names of all persons involved including witnesses.**

Manager/supervisor statement (describe any follow-up, corrective action taken or additional information regarding the incident/occurrence).

Person completing form:_____ **Date:**_____

Office Manager:_____ **Date:**_____

Practice Manager:_____ **Date:**_____

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