TDY MEDICAL STAFFING, INC.

Incident Report

CONFIDENTIAL

In the event there is an incident that warrants review by facility or company, employee is required to complete this form - be precise and truthful with all information requested. If something is not applicable, mark "N/A."

To be completed by employee

Facility Name	**Name of Patient Involved**
Address where incident occurred	**Facility Telephone**
Date & Time of Incident **Mo.**_____ **Day**_____ **Year**_____ **Time**_____	**Facility Employee Who Reported Incident** Name: _____ Specialty where Incident Occurred:_____

TYPE OF INCIDENT:

1.0 ☐ Building/Facility Security Staff/Patient Endangerment
2.0 ☐ Loss/Breakage/Theft
3.0 ☐ Suspected/Actual Abuse, Neglect, Endangerment
5.0 ☐ Refusal of Treatment
6.0 ☐ Missing Narcotics / Medications
Name of Narc/Med:_____
7.0 ☐ Medication Error
7.1 ☐ IV Medication
7.2 ☐ Oral Medication
7.3 ☐ IM Medication
Name of Medication : _____

8.0 ☐ Not Following Facility Policy/Procedure
9.0 ☐ Equipment/Medical Device Malfunction
10.0 ☐ No Call and/or No Show
11.0 ☐ Late Call Off
12.0 ☐ Employee Competency/ Training/ License/CPR Requirements
Do Not Return
Clinical
13.0 ☐ Clinical Procedure:
Type:_____
13.1 ☐ Inadequate Patient Care
13.2 ☐ Clinical Documentation
Do Not Return
Professional
13.3 ☐ Unprofessional Behavior:_____
13.4 ☐ Patient Abandonment

Patient Injury

1.0 ☐ Attended Fall
2.0 ☐ Unattended Fall ☐ No Injury or:
2.1 ☐ Fracture
2.2 ☐ Contusion, Cut, Laceration
2.3 ☐ Sprain/Strain
3.0 ☐ Anaphylaxis
4.0 ☐ Cardiac Arrest/Respiratory Arrest/Distress
5.0 ☐ Death

General

*** Identify and describe type of incident if it does not fall under any identified category**

6.0 ☐ Other: _____

Employee Involved:	**Employee Credential:**	**ADP Payroll Number:**

DESCRIBE INCIDENT or PATIENT INJURY:

_____
_____
_____
_____

_____

Follow-up Requested by	**Follow-up Communicated By**	**Date**

Account Manager:	**Date:**	**RDOCS Review:**	**Date**

Corporate Review (signature)	**Date**

DO NOT PHOTOCOPY