OFFICE:  □ Northern  □ Southern

Type of Adverse Event:  □ Fall  □ Equipment Malfunction  □ Smoking Related
(Check all that apply)  □ Fall  □ Equipment Malfunction  □ Smoking Related
□ Fire Related  □ Self Inflicted  □ Treatment Related
□ Fire Related  □ Self Inflicted  □ Treatment Related
□ Self Inflicted  □ Treatment Related  □ Loss of Personal Property
□ Other

Patient Name: ____________________________  Patient MR Number: ____________

Date of Incident: ______________ Time of Incident: ____________ AM/PM

Location of Incident: ____________________________

Witnesses: __________________________________________

Description of Incident: __________________________________________

Did Equipment Cause the Incident? □ No  □ Yes (List Type): ____________________________

Activity Level of Patient Prior to Incident: □ Chair/Bed Bound
□ Independent Ambulation
□ Assisted Ambulation

Description of Injury Related to Incident: __________________________________________

Was an Emergency Room Visit Required? □ No  □ Yes, if Yes what facility

Physician Notified: Date: ____________________________  Time: ____________ AM/PM

Treatment Ordered: __________________________________________

Policy: Adverse Events CP230
Safety Measures/Teaching Implemented for Prevention:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Patient Plan of Care Updated **Date:** ________________

Fall Risk Assessment (MACH-10 form) re-administered (after each Incident): □ Yes □ No

Medications Reviewed (after each Incident): □ Yes □ No

Name of Family Member/Health Care Proxy Notified: ________________________________

Date: ________________ Time: ________________ AM/PM By Whom: ________________

Staff Reporting Incident: ________________________________ Date: ________________

Patient Care Coordinator ________________________________ Date: ________________

Reviewed by Executive Director ________________________________ Date: ________________

**Original to Quality Assurance Coordinator**

________________________________________ Date: ____________________

QA Signature

Reported to QA Committee: ________________________________ (Date)