Occurrence Report

Company:_____ Office:_____ Date Received:_____ Time Received:_____

WHO: Patient (witnessed) Employee SSN #: _ _ _ _ _ _ _ _ _

Patient/Employee Name:_____ ID Number:_____

WHAT: Fall* Back injury* Auto accident* Med Error** Needlestick***

Loss and/or destruction of property Other:_____

Describe occurrence:_____

_____

WHERE: _____

WHEN: Date of occurrence:_____ Time of occurrence:_____ am / pm

IF ACCIDENT/INJURY: (*Note - If employee accident/injury, complete Workers Compensation form also)

WHY:

Physical Reasons		Environmental/Safety Reasons	
Vertigo/Dizziness	Tripped	Equipment Failure	Water on floor
Mental Status	Poor Balance	Slipped on scatter rug	Pathways cluttered
Arose too Quickly	Poor Vision	No siderail / siderail down	No nightlight
Lifting / Bending incorrectly		Didn't use assistance/assistive device	
Other:_____		Other:_____	

****IF MEDICATION ERROR:**

WHY: extra dose missed dose wrong dose wrong med Other:_____

Patient Name:_____ ID #:_____ Medication:_____

FOLLOW UP:

Physician notified	Yes	No	NA	Date:_____	Time:_____
Supervisor notified	Yes	No	NA	Date:_____	Time:_____
Compliance Officer notified	Yes	No	NA	Date:_____	Time:_____
Seen by Physician	Yes	No	NA	Date:_____	Time:_____
Patient hospitalized	Yes	No	NA	Date:_____	Time:_____
Employee returned to work	Yes	No	NA	If no, last day worked:_____	

Other:_____

Treatment ordered:_____

Comments:_____

_____

_____

Signature of Person Preparing Report:_____ Date:_____

Signature of Supervisor/Administrator:_____ Date:_____

****Report on the Sharp's Injury log*

Infection Report

Company:_____ Office:_____ Date Received:_____ Time Received:_____

WHO: Patient Employee SSA #: ___ __ ____

Patient/Employee Name:_____ ID Number:_____

WHAT:

Respiratory	Wound	Urinary	Other:_____
IV Site	Surgical	Foley	_____
GI	Stasis Ulcer	Date inserted	_____
Blood	Pressure Ulcer	_____	
	Other:_____	By:_____	_____

Comments: _____

_____

WHERE: Home ALF Nursing Home Other facility:_____

WHEN: Date of Infection:_____

WHY: Symptomatic Asymptomatic Verified by: Culture X-ray

VRE* MRSA**

PATIENT STATUS: Antibiotic Ordered Hospitalized: Date admitted:_____ Hospital:_____

Expired Resolved

STAFF STATUS: Number of days off work:_____

Returned to work on:_____

NOTE - Report only Patient Infections that develop 48 hours after admission to home care

Comments:_____

_____

_____

_____

_____

_____

_____

_____

**Vancomycin-Resistant Enterococcus, **Methocillin-Resistant Staph Aureous*

Signature of Person Preparing Report:_____ Date:_____

Signature of Supervisor/Administrator:_____ Date:_____