CAROLINA THERAPY SERVICES

Patient Incident/Accident Report

Facility:

Employee Name: **Full Time/PRN:**

Job Title:

Length of Time in this Position:

Supersivor Name:

Patient Name: **Male/Female:**

Patient Age: **Patient Weight:**

Patient Diagnosis:

Today's Date:

Date of Incident:

Time of Incident: am pm

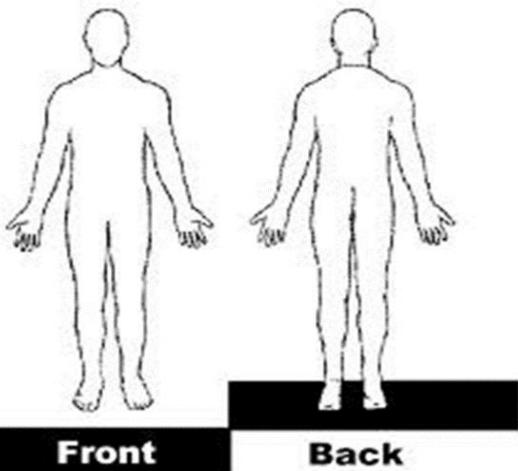
Statement of Incident; What happened; Why it happened; Causes; Equipment Used

Location of Incident within the facility?

Was the patient injured? **Yes/No**

Gait Belt in use? **Yes/No**

Location of Injury:



Type of Injury:

1. **Lacertion**
2. **Hematoma**
3. **Abrasion**
4. **Burn**
5. **Swelling**
6. **Skin Tear**
7. **None Apparent**
8. **Other (Spefify below):**

Was therapist following Physician approved POC & Observing precautions? **Yes/No**

Details if needed:

What level of assistance was staff providing:

What level of assistance should the patient of had for this task:

Was Employee Injured? **Yes/No** *If yes, AD must be notified & Workers Comp Incident* Report must be *completed and submitted to Corporate Office on day of incident.*

Was first aid adminstered? **Yes/No**

If Yes, type of care provided, by whom, & time provided:

Did incident result in a patient transfer out of facility for medical care? **Yes/No**

If yes, provide details: ____________________

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Incident Witness? **Yes/No** *If Yes, Witness Name:* ____________________

Was Administration at Facility Notified? **Yes/No**

Was Facility Incident/Accident Report Completed? **Yes/No**

Was Area Director Notified? **Yes/No** *If Yes, Date Notified* ____________________

Via Email, Fax, Phone, In Person (Circle One)

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Signature of Employee Date:

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Signature of Supervisor Date:

Supervisor Statement:

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Supervisor Signature **Date:**

Statement of Witness to Patient Incident:

Date of Incident:		**Did you see the incident involving the patient**	
Time of Incident:		**happen?**	**Yes/No**

Describe the incident? What did you see, hear, do, etc?

Witness Signature **Date:**

Corporate Use Only:

Area Director Signature Date:	AD Investigation Required?	**Yes/No**
	If Yes, Report Completed?	**Yes/No**
Clinical Specialist Signature Date:	Clinical Investigation Required?	**Yes/No**
	If Yes, Report Completed?	**Yes/No**
President Signature Date:	*Did incident result in disciplinary action for Employee?*	**Yes/No**
	Discipliary Action Taken:	
Follow Up Required? **Yes/No**	**Investigation Completed?**	**Yes/No**
Details for Follow Up,		
Liability Insurance Company Notified? **Yes/No**	*Date Notified,*	

Updated 2/8/2018