CAROLINA THERAPY SERVICES

Office Use

Type of Incident: _____
Injury: Y/N **Safety Protocol followed: Y/N**
Education Provided:Y/N
HR file: Y/N

Patient Incident/Accident Report

Facility: _____

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

Job Title: _____ **Length of Time in this Position:** _____

Supervisor Name: _____

Patient Information:	Patient Name:	
Male/Female:	Patient Age:	Patient Weight:
Patient Diagnosis:		

Today's Date:			
Date of Incident:			
Time of Incident:		am	pm

Report should be completed at the time of the incident.

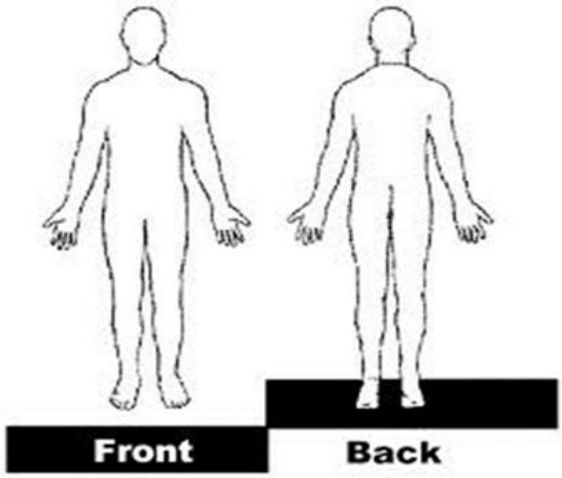
Send the completed copy to katien@carolinatherapy.net and bradm@carolinatherapy.net

Employee Statement of Incident:
Include ( )What occurred ( )Why incident occurred ( ) Equipment used ( ) Location of incident

Was the patient injured?	**Yes/No**	**Gait Belt in use?**	**Yes/No**

Signature of Employee Date:

Location of Injury: (To be completed by Employee)



Type of Injury:	
1. Lacertion	
2. Hematoma	
3. Abrasion	
4. Burn	
5. Swelling	
6. Skin Tear	
7. None Apparent	

8. Other (Spefify below):

To Be Completed by Supervisor:

Supervisor Statement:

Signature of Supervisor Date:

Has the employee been involved in any other patient incidents in the last 12 months?
If so, how many including this incident? _____

Was therapist following Physician approved POC, providing appropriate level of supervision & observing precautions?

Yes/No *Details if needed:*

Was Employee Injured? **Yes/No** *If yes, AD and HR must be notified immediately*

Was onsite medical care adminstered to the patient? **Yes/No**

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

Did patient require additional medical care? **Yes/No**

If yes, provide details and attach any records or x-rays obtained :

Was Area Director Notified? Date:_____ How? (Circle) Email, Phone, Fax

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

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

Was the Facility provided a copy of CTS incident report?	Yes/No

To Be Completed by Witness:

Statement of Witness to Patient Incident:

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

Witness Signature **Date:**

Corporate Office:

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**
Director of Compliance & Clinical Services Signature	Date:	*Did incident result in disciplinary action for Employee?*	**Yes/No**
		Disciplinary Action Taken:	
		Clinical Investigation Required?	**Yes/No**
		If Yes, Report Completed?	**Yes/No**
Follow Up Required?	**Yes/No**	**Investigation Completed?**	**Yes/No**

Details for Follow Up,

Liability Insurance Company Notified?	**Yes/No**

Updated 2/7/2024