Bridge House Corporation

INCIDENT REPORT

Incident Date: _____ Time: _____ Location: _____

Persons Involved:

Person Served: PS1: _____

Person Served: PS2: _____

Staff: S1: _____ Position: _____

Staff: S2: _____ Position: _____

V1:_____ Visitor's phone number _____

Incident Description: (Facts only: what, when, who, how)

_____

_____

_____

_____

_____

_____

Immediate Action Taken:

_____

_____

Pertinent Consumer and/or Other Information: (Diagnosis, Medications)

_____

_____

Report Prepared by: _____ Date: _____

----------Do Not Write Below----------

Supervisors Comments:

_____

_____

_____

_____

Supervisor's Signature _____

Type of Incident: (Place PS1, PS2, S1, S2, V1 by the type of incident)
_____ Unexplained Death
_____ Natural Death
_____ Accidental Death
_____ Suicide
_____ Suicide Attempt
_____ Consumer Self Abuse
_____ Consumer Injury
_____ Consumer Fall
_____ Visitor Injury
_____ Visitor Fall
_____ Assaultive Behavior
_____ Alleg. Sexual Activity
_____ Medication Incident
_____ Adverse Medication Reaction
_____ Medical Emergency
_____ Alleg. Consumer Abuse
_____ Alleg. Neglect
_____ Alleg. Sexual Abuse
_____ Alleg. Criminal Activity
_____ Staff Injury
_____ Staff Fall
_____ Property Damage
_____ Fire
_____ Medication Error
_____ Fire Alarm
_____ Infectious Disease
_____ Contraband Located
_____ Vehicle Accident
_____ Physician's Order Errors
_____ Restraint
_____ Other:_____
Did injury require: (Check one)
_____ Off-site medical care
_____ Physician or Nurse on-site attention
_____ First aid-care
_____ No care
Were Universal Precautions Used?
Yes: _____ No: _____ N/A: ____
If staff injury, was HR notified?
Yes: _____ No: _____
Indicate attached documents: (Check)
_____ Refusal of Medical Care
_____ Progress Notes
_____ Medication Error Report
Other:

_____

CIRs are not to be noted in client chart.
QM Use Only:
Date CIR report was received: _____

Was follow-up required: Yes: ___ No: ___